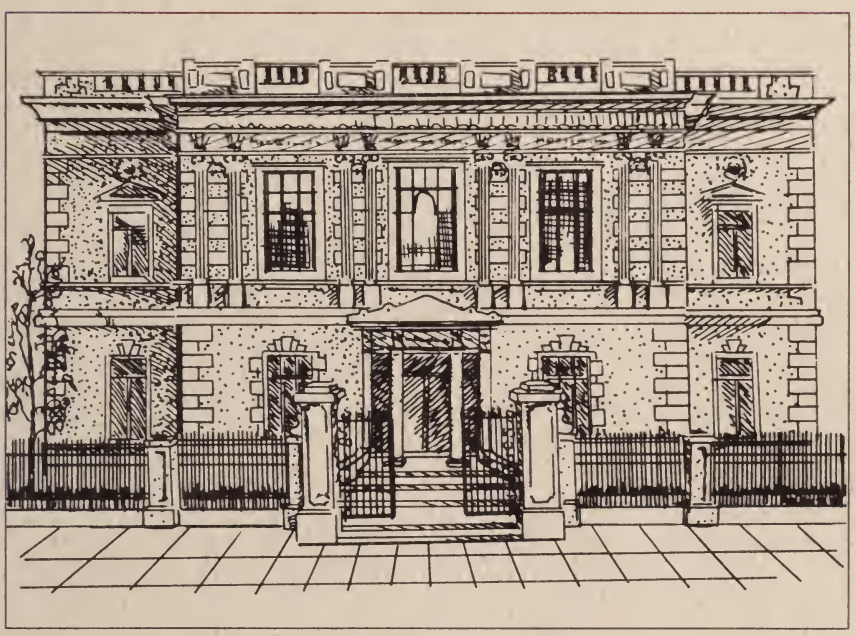
TRANSACTIONS & STUDIES



of the
COLLEGE OF PHYSICIANS
OF PHILADELPHIA

Series V
Volume XIX December 1997
Volume XX December 1998

LIBRARY OF THE
COLLEGE OF PHYSICIANS
OF PHILADELPHIA
FEB 28 2006

COLLEGE OF PHYSICIANS OF PHILADELPHIA
1997 and 1998

OFFICERS

Alfred P. Fishman M.D., *President*
Charles T. Lee, Jr., M.D., *President Elect*
Edward J. Resnick, M.D., *Secretary*
George Ross Fisher, III, M.D., *Treasurer*
Marc S. Micozzi, M.D., Ph.D., *Executive Director*

COUNCIL

Mark W. Allam, V.M.D.*
Lewis W. Bluemle, Jr., M.D.
Michael J. Bradley
Robert H. Bradley, Jr., M.D.
Luther W. Brady, Jr., M.D.
Robert E. Campbell, M.D.
David Y. Cooper, M.D.
Edward S. Cooper, M.D.
Lewis L. Coriell, M.D., Ph.D.
Renée C. Fox, Ph.D.
Joseph S. Gonnella, M.D.
Richard A. Lippin, M.D.
Allen R. Myers, M.D.
Emily H. Mudd, Ph.D.*
Eric G. Neilson, M.D.
W. Robert Penman, M.D.
Robert D. Reinecke, M.D.
Jonathan E. Rhoads, M.D.
Brooke Roberts, M.D.
George P. Rosemond, M.D.
Charles R. Shuman, M.D.
Howard M. Snyder, M.D.
Thomas M. Vernon, Jr., M.D.

*Deceased

* * *

Watson Publishing International

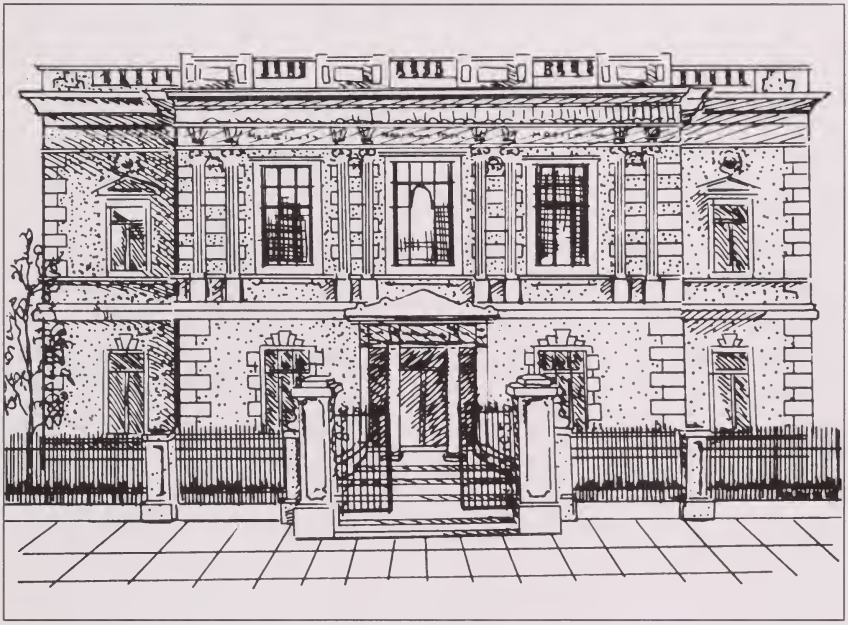
* * *

Transactions & Studies of the College of Physicians of Philadelphia (ISSN 0010–1087) is published annually by the College of Physicians of Philadelphia, 19 South 22nd St., Philadelphia, PA 19103. Subscription correspondence should be sent to the journal at the same address. As of September 1997 subscriptions within the U.S.A. and Canada are $20.00, International $25.00. Back issues, $15.00 each. Cancellations, reports of missed issues, and refunds must be in writing and on an official letterhead.

Scholarly submissions should be sent to Editor, Transactions and Studies, College of Physicians of Philadelphia, 19 South 22nd St., Philadelphia, PA 19103, Attention: Sofia Sereda, Library Administrative Assistant.

Transactions & Studies of the College of Physicians of Philadelphia is indexed in *Biological Abstracts*, *Chemical Abstracts*, and *Index Medicus*.

TRANSACTIONS & STUDIES



of the

COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XIX December 1997

Copyright © 1999 by the College of Physicians of Philadelphia

TRANSACTIONS & STUDIES OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XIX December 1997

Editorial v
DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1997 1
ALFRED P. FISHMAN

Annual Report of the Katherine A. Shaw Public Services Division 7

Financial Report of the College of Physicians of Philadelphia, July 1996–June 1997 13

Forum on Disability and the Presidency of the United States

Opening Remarks 15
SENATOR ARLEN SPECTER

When the President is the Patient 19
MARC S. MICOZZI

President Lincoln's Fatal Wound: An Experimental Study 25
JOHN K. LATTIMER

Resuscitating the Twenty-fifth Amendment: Mandating a Second Opinion for the Determination of Presidential Disability 39
BERT E. PARK

The Illness and Death of President Franklin D. Roosevelt 53
HUGH E. EVANS and ROBERT H. FERRELL

Visitor Survey after viewing "When the President is the Patient" 65
COLLEGE STAFF

Feature Articles

Innoculation, Patients, and Physicians: The Transformation of Medical Practice in Philadelphia, 1730–1810 67
SARAH BLANK DINE

A Nineteenth-Century Literary Physician: S. Weir Mitchell's Medical Work and Imaginative Writing 95
NANCY CERVETTI

From the Historical Collections of the Library

Mary Putnam Jacobi's Letter of Protest to S. Weir Mitchell
As introduced and transcribed by 110
NANCY CERVETTI

Memoir

Daniel Leonard Shaw (1922–1997) 115
ROBERT H. BRADLEY, JR.

Notes on Contributors 117

Editorial

Volume XIX, Series V is the one hundred and eighteenth volume of *Transactions and Studies* that the College has published over the past 157 years. In the past, interruption of the College's publication schedule often indicated difficulties on a national level, such as the Civil War or World War II. Fortunately, the delay in preparing volume XIX was due to more limited difficulties, in particular the departure of key figures in the College's Historical Division.

It has been my pleasure over the past six months to assist the College in assembling volumes XIX and XX of *Transactions and Studies*, thus returning the publication to its annual schedule. For the most part, the effective format introduced by former editor, Tom Horrocks, was retained. In addition to important institutional information regarding the College's activities and resources, both volumes showcase scholarly activity promoted by the Library, the Mütter Museum, lecture series, and gallery exhibitions. In this respect volume XIX is especially rich, as it offers both a sampling of material from the College's initiative on presidential disability and the Twenty-fifth Amendment of the Constitution, as well as two full-length studies based on important items in the College's collection of historical manuscripts.

As detailed in the President's Report, the College's initiative on presidential disability and the Twenty-fifth Amendment was very rewarding. The invited speakers published in this volume present an array of perspectives and approaches but they also clarify some unifying themes that are currently being incorporated into a position paper on the subject of presidential disability.

Senator Arlen Specter opened the Forum on Presidential Disability by reviewing the history of the Twenty-fifth Amendment and introducing the important distinction between impairment and disability. Bert Park develops this important distinction more fully in his contribution, "Resuscitating the Twenty-fifth Amendment: Mandating a Second Opinion for the Determination of Presidential Disability." Park, like his fellow speakers Hugh Evans, Robert Ferrell, and Jonathan K. Lattimer, derives his perspective on presidential dis-

ability from specific historical material. Their work demonstrates the vital connection between thorough historical research and contemporary policy debates.

In addition to tackling weighty political issues, the papers in this volume provide compelling historical narratives that inform us about the practice of medicine in the past. Dr. Lattimer's technical yet colorful discussion of President Lincoln's assassination includes survival rates culled from Civil War records. Historian Sarah Blank Dine's work shows us the economics of medical practice in colonial Philadelphia, including the cost of inoculation and the extent of contract practice even among elite physicians. The volume's final contributor, Nancy Cervetti, is but one of the many scholars who have visited the College Library recently, in order to make use of the S. Weir Mitchell Papers purchased in 1990.

DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1997

Alfred P. Fishman, M.D.

If Dr. Benjamin Rush, Dr. John Morgan, and the other eminent founders of this institution could be here with us now, how would they view what the College of Physicians is doing today? My guess is that they would feel right at home. I wish they could visit our world-class medical history library, our distinguished medical museum, the new College gallery, the C. Everett Koop Community Health Information Center (CHIC), and our medicinal plant garden. Now, Dr. Rush was a very critical man and would be unlikely to spare us completely if he returned. However, I think that Dr. Rush and his colleagues would recognize that we have remained true to the goals of our founders.

Over the past year, the College has worked to advance the cause of public health and to recapture the "lost" history of medical ethics. It has helped policy makers to explore vital connections between medicine's past and our own time. We presented successful programs designed to educate medical professionals as well as the general public. Let me take just a few minutes to review what has been accomplished.

I am particularly proud of the compelling programs that the College sponsored or co-sponsored this year. More than three hundred Fellows and guests were here to welcome Nobel Laureate Dr. Joshua Lederberg to the College in April. As part of its coverage of the event, *The Philadelphia Inquirer* published Dr. Lederberg's warning that "We are more vulnerable than ever" to the threats posed by infectious diseases. Dr. Lederberg's speech provided a preview of an important 1998–99 initiative by the College to educate the public and the medical profession about the return of deadly infectious diseases, diseases that had become almost unknown in North America and Europe.

Among the many commitments that the College sustains, few are more important than support for medical ethics. In March, the College and the American Medical Association co-sponsored a dinner in

Mitchell Hall as part of a symposium on the 150th anniversary of the AMA's code of ethics. *New York Times* columnist William Safire was the keynote speaker for the event. The dinner attracted more than four hundred medical ethicists, historians, and medical pioneers, such as Dr. Michael De Bakey, to the College.

In 1994, the College founded a special section on biomedical ethics under the leadership of Arthur Caplan, Ph.D. of the Center for Bioethics at the University of Pennsylvania. I would like to take this opportunity to salute Dr. Caplan for his contribution and to welcome his successor, Thomas Langfitt, M.D. Dr. Langfitt will head a reconstituted Section on Medical Ethics that will begin sponsoring programs in the fall.

No scholarly discipline can afford to neglect its own past and this warning is particularly true for the field of medical ethics. With a world-class medical history library, a distinguished medical museum, and strong links with other academic centers, few institutions could be better prepared to launch an institute dedicated to the documentation and interpretation of the history of medical ethics. We have taken the first steps toward establishing support for such an institute here at the College.

Among the many superb programs offered during 1997, few gave our fellowship greater pleasure than the inaugural Jonathan E. Rhoads Commemorative Lecture, which we co-sponsored with the American Philosophical Society and the Department of Surgery of the University of Pennsylvania. It is appropriate that the first lecturer was an expert on health policy, the distinguished former Senator Nancy Kassebaum Baker. Senator Kassebaum spoke at the Philosophical Society. We anticipate that next year's program will be held here at the College.

Michael Beschloss, Ph.D. has never served in the U.S. Senate, but this distinguished historian has devoted his career to studying the American presidency. Dr. Beschloss was one of the six nationally known historians who spoke here as part of our lecture series on presidential health. This lecture series, which was held during October and November of 1997, complemented our very successful exhibition: "When the President is the Patient." The exhibition, which opened in October of 1997, generated an unprecedented degree of international media attention for the College. Due to popular demand, the gallery exhibition has been extended through August 15, 1998. This was done in part to give students in Greater Philadelphia's public and private schools more time to see this popular and informative exhibit.

It would be impossible for me to discuss programs here at the College without expressing great satisfaction at the positive and productive way that the College and its sections work together to bring timely and engaging speakers here. The lecture series on presidential health was co-sponsored by our section on Public Health and Medical History. I would like to thank both the American Medical Association and Right Associates for helping to make the series possible. Dr. Lederberg's talk at the College was also co-sponsored by our Public Health Section. In addition, the Section on Medical History brought Thomas Bonner, Ph.D. here to discuss the lives of nineteenth-century medical students, while our Arts-Medicine section invited Naj Wikoff from the Koop Institute at Dartmouth to discuss the positive impact that the arts have had at a major academic medical center. I would also like to acknowledge the continuing relationship between the College and a study group on medical informatics. The group is co-chaired by College Fellows Russel Maulitz, M.D., Ph.D, Stanley Schwartz, M.D., Ph.D., and Marvin Gozum, M.D. This group will help us to prepare for and meet the challenges of medical communications in the next century.

No cultural organization can afford to enter the next century without a strategic plan. This year has been devoted to developing such a plan. The process began with two retreats for members of the College Council on January 6th and March 30th, 1996. This led to the creation of two College task forces. One group focused on the future of the Library and was headed by Dr. Reinecke, while the second group looked at Board and membership development and was chaired by Dr. William Kissick.

After several public meetings and considerable study by Council members, the recommendations of Dr. Reinecke's group were accepted. Among these was a commitment to the idea that the College should enhance and preserve its historical library even if this requires substantially reducing the library's general medical reference materials. This approach will allow the College to focus its precious resources in areas where it can make a unique contribution to the medical humanities. Dr. Kissick's group has also completed their work and issued a series of recommendations that are currently being reviewed by the College's Council.

The College's new Division of Public Services had a banner year. Driven by a combination of new extended hours, a realistic admission price, and promotion of the College as a package including the new College Gallery, the C. Everett Koop Community Health Information Center, medicinal plant garden, and Mütter Museum, pub-

lic revenue at the College increased by 300 percent and visitation by 50 percent.

I would like to take this opportunity to point out that no element of the College has attracted the interest and attention of outside funders to the degree that the Koop Center, known as Koop CHIC, has. As of today, grants for the Koop Center are presently in the pipeline from two different agencies of the U.S. Public Health Service—a first for this institution. A grant from the Health Resources and Services Administration (HRSA) will link the Koop Center with federally supported community health clinics in Philadelphia. Under the terms of this grant, the College will create "baby CHIC's" within several community clinics. College staff will also provide training designed to help clinic physicians take advantage of the information resources available to them on-line. A second grant from the Centers for Disease Control and Prevention (CDC) is intended to evaluate the Koop Center as a national model of a facility offering physician-generated health information to the community at large.

It has also been a busy year for the College's Wood Institute and the historical medical library. In May 1997, the Wood Institute sponsored a scholarly conference on drug and alcohol use in the United States from 1800 to the present. This conference brought the foremost scholars in this field to the College and was the subject of an article in *J.A.M.A.* in 1997. The conference was supported by the Groff Family Memorial Trust, the Barra Foundation, and the Benjamin and Mary Siddons Measey Foundation.

For the second year in a row, the Institute supported eleven Resident Research Fellows. This program was supported by the Benjamin and Mary Siddons Measey Foundation and the Women's Committee of the College. Meanwhile, Scholar-in-Residence, Peter Allen, continued to write an important cultural history of AIDS. Dr. Allen also gave a talk during the Institute's Seminar Series in the History of Medicine, a series now in its thirteenth year.

The impact of these developments was evident in a variety of different ways. Nearly one hundred new Fellows joined us during this period and nine who had quietly drifted away over the years decided that they wanted to come back. I am delighted that our annual giving campaign is running ten to fifteen percent ahead of last year's effort. I would also like to note that we are doing an unprecedented amount of network building among individuals, corporations, foundations, and policymakers. This effort should result in important additional resources for the College.

It is no secret that the College operates a world-class library, a distinguished medical museum, a gallery, a community health information center, a garden, a membership organization, and a gorgeous building on an annual budget of approximately $2.5 million. Any one of these elements could well consume the entire budget. Yet we have decreased the annual spending of the endowment from 9 percent to a more sustainable 6 percent and have also cut costs in the face of our declining draw on the endowment. The current net result is an annual deficit of $300–400,000 a year. Although we receive revenue from a multitude of sources, both the amount and the timing has been problematic. Nonetheless, our outside audit was successful, our investments are doing well (matching S&P 70/30 Index) and we are taking prudent steps to reduce—and eventually eliminate—our deficit by 1998. Looking at the big picture, I am excited by our present achievements and our future prospects. The College's rendezvous with destiny continues.

Katherine A. Shaw Division of Public Services and Programs Annual Report July 1996–June 1997

The Katherine A. Shaw Public Services and Programs includes the C. Everett Koop Community Health Information Center (CHIC), the College Gallery, the Mütter Museum, the Reception Desk and Gift Store, and the Special Events and Facilities Rental program.

The C. Everett Koop Community Health Information Center (CHIC)

CHIC encourages the public to take a more active role in the management of their health by providing ready access to a broad spectrum of current information on medicine, health maintenance, disease prevention, and health care services. The culturally diverse collection of materials includes books, journals, newsletters, videos, computer databases, CD-ROM products, Internet access, and pamphlets for adults, children, and adolescents in both English and Spanish. From July 1996 to June 1997, CHIC's hours were the same as the hours of the College Gallery and Mütter Museum: Monday through Saturday from 10 A.M. to 4 P.M. Hours were reduced to Tuesday through Saturday from 10 A.M. to 4 P.M. at the end of June 1997.

The restructuring of the Library and its new focus on historical medical materials, described in the President's Report, meant that modern reference services were subsumed under CHIC. The modern reference services provided through CHIC during FY 1997 included online computer literature searches, in-depth reference questions, and queries about the College's Library collection. Six thousand, four hundred and twenty-five (6,425) individuals visited CHIC in FY 1997.

CHIC's services were actively promoted through various activities, including development of a Koop CHIC logo, a CHIC brochure, public service radio announcements, signs on SEPTA buses from October–December of 1996, banners for Koop CHIC on the front and rear of the College building, relabeling of College directional signage, including participation in WALK PHILADELPHIA (a citywide pedestrian route), CHIC listings in the blue and yellow pages of the telephone directory, CHIC pages on the College Website, and participation in local health fairs.

The College is currently conducting an on-site survey of CHIC users to determine how visitors hear about CHIC, where they obtain their health information, their satisfaction with CHIC services, and their willingness to pay for these services. Focus groups will be conducted with intermediaries that interact with the general population, including school teachers, librarians, social workers, home health workers, and corporate wellness program directors in order to determine CHIC's value to them and the population with which they interact.

In 1997 the College received a two-year, $40,000 grant for CHIC from the Connelly Foundation for educational outreach to school groups. School groups are being encouraged to learn more about health and medicine by expanding a visit to the Mütter Museum and College Gallery by including a visit to the CHIC. Student groups visiting the CHIC are given a brief orientation to the resources available in the CHIC. They are encouraged to utilize the CHIC as part of their studies and they are asked to tell their family members about the resources available for investigating their own health concerns.

The College continued its efforts to integrate the information resources of CHIC with the educational opportunities of the Museum and Gallery. CHIC staff developed information fact sheets on diseases discussed in the College's Gallery exhibition "When the President is the Patient." These fact sheets, which were made available in the Gallery, provided additional information on health issues raised by the Gallery exhibit, including references to books, pamphlets, articles, and Internet sites. Signs were also positioned throughout the Museum and Gallery encouraging visitors to stop by CHIC for further information on topics discussed in the exhibition.

Mütter Museum and College Gallery

Visitors and Income

Attendance figures for FY 1996 totaled 24,123, a thirty percent increase from 18,312 during the previous fiscal year. This dramatic increase was probably due to changes in operating hours. In June of 1996, the public hours of the College Gallery, Mütter Museum, and the C. Everett Koop Community Health Information Center changed from four to six days a week, Monday through Saturday, with the weekend generally drawing the highest daily attendance during the school year.

The proportion of individual visitors compared to the number of visitors on prearranged group tours continued a trend that began in 1989. The number of individual visitors far exceeded the number of visitors on group tours. In FY 1997, the number of group tours was 28% of the total number of visitors. This percentage has varied between a high of 37% (1991) to a low of 24% (1996) over the past nine years and reflects the relatively slow increase in the numbers of group visitors compared to the 3–4000 annual increase in individual visitors since 1992.

Reception Desk and Gift Store

Museum and Gallery admission fees were previously collected in the Museum. Since the "Say AHH!" exhibition in the Gallery, admission fees have been collected at the Reception Desk. During the fall of 1996, the College opened a small gift store in the Reception area operated by a newly hired receptionist, Dori Panzer. College postcards, calendars, and health-related publications and novelties are available for purchase through the College's gift store.

Museum/Gallery Tours

Due to the dedicated efforts of the Co-Chairpersons of the College Guide Program, Mrs. Robert Booth and Mrs. John Brobeck, the College has had an active museum guide program. Museum guides include Mrs. Emily Baxter, Mrs. E. Howard Bedrossian, Mrs. Robert Booth, Mrs. John Brobeck, Mrs. James B. Carson, Mrs. Kenneth Cundy, Mrs. Marshall Guthrie, Mrs. William G. Minster, Mrs. Edward Schulman, Dr. Joseph M. Winston, and Mrs. Jean Conroy. In 1997, Dori Panzer, College Receptionist, assumed responsibility for

tour coordination with the guides. Mrs. Bedrossian and Mrs. Brobeck are sharing the "role" of Tour Guide liaison to the Womens' Committee and have begun to focus their attention on recruiting more tour volunteers. During FY 1997 approximately 336 groups visited the Mütter Museum and College Gallery.

With the assistance of Mrs. John Brobeck and Mrs. Robert Booth, Marjorie Smink, M.S., Director of the Library, updated the College visitors' orientation slideshow and script. The slideshow, which contains thirty slides illustrating various parts of the Mütter Museum, College Gallery, Medicinal Herb Garden, C. Everett Koop Community Health Information Center, and Library, is presented by tour guides to groups visiting the College.

Special Projects, Lectures, and Exhibits

In May of 1996, a special exhibit on the March of Dimes and the campaign against polio was installed in the Mütter Room, including photographs documenting the history of the March of Dimes Foundation (on loan from the CIGNA Corporation), alongside the museum's own 1939 Emerson iron lung. This exhibition complemented the College Gallery exhibition on Presidential health, particularly the sections on Franklin Roosevelt. The display of foreign bodies retrieved by Chevalier Jackson, one of the founders of otolaryngology, was refurbished through the efforts of a volunteer.

Manager of Museum Services Lynn Brocklebank (listed as Collections Manager in FY 1996) supervised the removal of the "Say Ahh!" exhibition, the installation of the presidential health exhibition, and chaired the College's Risk Management Committee as it prepared a disaster plan for the College as part of a grant funded by the William Penn Foundation through the Conservation Center for Art and Historic Artifacts. Lynn Brocklebank resigned her position in January 1997 to become the Collections Manager at the Hillwood Estate in Washington, D.C.

Lectures

On February 20, Dale C. Smith, Ph.D. presented the 1997 Thomas Dent Mütter Lecture on the topic, "'Young Physic': A Sesquicentenary Review." His title was taken from an 1846 essay by Sir John Forbes, in which he challenged the traditional allopathic physicians of his day to re-evaluate their practice of so-called scientific medicine in light of the growing success of a "new" therapeutic system,

homeopathy. Forbes called on them to practice "Young Physic", a renewed dedication to understand health and disease in a broader context.

Loans

The portrait of Alexander von Humboldt by Charles Willson Peale was lent to the Trust for Museum Exhibitions for a traveling exhibition on the Peale family that opened at the Philadelphia Museum of Art before going to the San Francisco Museum of Fine Art and the Corcoran Gallery in Washington, D.C.

A set of Civil War-period surgical instruments and related medical and surgical artifacts were lent to the Germantown Historical Society for a exhibit on Louisa May Alcott.

The Museum's iron lung was lent to the CIGNA Corporation for an exhibition on the March of Dimes. The exhibition was then lent to the Mütter Museum and displayed there.

In addition, consultation was provided for an exhibition of artifacts relating to University of Pennsylvania physicians installed in the lobby of the Ravdin Building of the Hospital of the University of Pennsylvania and for an exhibit on the hand at Dickinson College.

Accessions

Objects received into the collections during FY 1997 included homeopathic materials from Mrs. Robert Hall; three doctors' bags and contents from Kenneth Ulansey; a large collection of lantern slides, 35mm slides, and x-ray images showing orthopedic pathology from Howard H. Steel, M.D.; a uterine dilator from Luigi Mastroianni, M.D.; miscellaneous medical instruments from Ann Talmadge; an X-ray tube from Halbert Fillinger, M.D.; and a plaque from the U.S.S. William Osler Liberty Ship from Ralph Crawshaw, M.D. Paucity of collections management staff, and the large amount of time spent on loans and exhibitions in the College Gallery meant that no accessioning could be completed for the past fiscal year.

College Gallery

The College Gallery's second exhibition, "When the President is the Patient," opened in October 1996. This exhibition traces the history of presidential disability and raises questions about how much the American public has ever known about the health of the chief exec-

utive and whether proper safeguards are in place for monitoring presidential fitness. Artifacts and photographs from the museum's collections, including the Cleveland tumor, related surgical instruments, and a wax model of a carbuncle, were featured, as well as items from the Franklin D. Roosevelt Library and Museum, the Woodrow Wilson House, the Library of Congress, and the National Museum of Health and Medicine. Visitors were given a chance to "vote" on some of the issues raised by the exhibit.

Museum, Library, and Public Services staff developed the script and selected artifacts and images. The script was coordinated by Thomas Horrocks, Director of Historical Programs and Services, with assistance from Gretchen Worden, Director of the Mütter Museum, and Andrea Kenyon, Director of the Katherine A. Shaw Division of Public Services and Programs. Prior to her departure in January of 1997, Collections Manager Lynn Brocklebank supervised loans and the installation of the College Gallery exhibition.

PBS commentator Michael Beschloss, Ph.D. spoke on "How Presidential Health Has Affected the Twentieth Century" as part of the opening reception for the exhibition. His talk was the first in a series of lectures presented in tandem with the exhibition. Speakers included Bert Park, M.D. on "Woodrow Wilson's Neurological Illness: Historical Significance and Future Implications"; Robert H. Ferrell, Ph.D. on "The Illness and Death of Franklin D. Roosevelt"; and John K. Lattimer, M.D., Sc.D. on "Medical and Ballistic Details of President Lincoln's Fatal Wound: An Experimental Study."

College Calendar

The College discontinued the Mütter Museum calendar, but sales of past issues brought in $5,000 in revenues to the College gift shop and substantially reduced the inventory of leftovers to the point where the 1994 and 1996 calendars are almost entirely sold out, and only approximately 200 remain from 1995.

A 1998 "Treasures of the College" calendar, printed by Becotte & Gershwin, was developed by a committee of College staff, who determined the format and content. The thirteen full-color photographs included images of the herb garden, library reading room, medical illustrations and bookplates, portraits, and sculpture. Images from the museum collections included an archival photograph of the museum in the 1880s, and a photograph of the giant and dwarf skeletons in the museum today. The calendars were distributed free to Fellows and sold in the College gift shop.

Annual Financial Report of the College of Physicians of Philadelphia: July 1996–June 1997

I. Commentary:

Fiscal year 1997 was an overall improvement from last year. The College's revenue of $3,482,247 was higher than last year while expenses of $2,818,015 were lower. Total assets, $12,553,930 were also greater than last year. All of these results led to a more favorable financial condition than prevailed during the same period last year. The College benefited from the increasing success of the C. Everett Koop Community Health Information Center (Koop CHIC), the Gallery, and other College programs as well as controlled spending and a total net gain on investments over the last year totaling $1,553,111. The financial data detailed below is excerpted from the audited financial statements prepared by the College's external auditors, MacDade Abbott, LLP.

II. Financial Data:

Operating Statement

Revenues	
Membership Dues	$ 330,350
Contributions and Grants	347,010
Facility Rental & Parking Lot Lease	420,976
Endowment Proceeds	1,856,060
Services Provided	527,851
Total Revenues	$ 3,482,247
Expenditures	
Programs & Services	$ 1,211,081
Plant & Depreciation	223,925
Benefits & Payroll Taxes	1,856,060
Management, Accounting, Overhead & Development	527,851
Total Expenditures	$ 2,818,015

Balance Sheet (June 30, 1997)

Assets	
Cash	$ 187,946
Accounts Receivable (net)	154,143
Notes Receivable (net)	40,924
Investments (cost)	9,452,652
Other Assets	74,300
Buildings, Furnishings, and Equipment (cost – net of depreciation)	2,643,965
Total Assets	$12,553,930
Liabilities	
Accounts Payable	$ 296,574
Other Liabilities and Accruals	286,645
Total Liabilities	$ 583,219
Net Assets	
Unrestricted (mostly property)	$ 2,232,475
Temporarily Restricted	3,784,277
Permanently Restricted	5,953,959
Total Net Assets	$11,970,711
Total Liabilities and Net Assets	$12,553,930

Throughout 1997 the College of Physicians of Philadelphia sponsored a series of related activities addressing the issue of presidential disability and the Twenty-fifth Amendment. Prominent speakers, a nationally acclaimed exhibition, and policy recommendations (pending approval) created a comprehensive approach to this significant topic. The following material, excerpted from the year's events, is intended to provide the flavor of what was discussed and accomplished, from Senator Specter's opening remarks to the opinion of visitors who saw "When the President is the Patient" in the newly opened College Gallery.

Forum on Disability and the Presidency College of Physicians of Philadelphia, November 19, 1997

Opening Remarks
Senator Arlen Specter

Good morning. I am pleased to have the chance to offer introductory remarks to those attending today's Presidential Health Forum at the College of Physicians of Philadelphia. I am sorry that I cannot be with you personally. I applaud the College leadership for arranging a Forum on the extremely important issue of presidential health.

The College of Physicians is an ideal sponsor for a forum on Presidential Health. The College is the oldest private medical society in the nation. It was founded in 1787, the very year the Constitution was written. One of its founders, Dr. Benjamin Rush, signed the Declaration of Independence. From the beginning, the College has worked to educate both the medical profession and the public about a wide range of public health and public policy issues including the risks associated with alcohol and tobacco use, the importance of good sanitation in homes and neighborhoods, the need to protect the purity of drinking water, and the merit of humane treatment for prisoners. The College's historic work has contributed to numerous laws and regulations designed to protect and enhance public health, including the formation of what has now become the United States Public Health Service. The College has a rich history of contributing to relevant public policy debates.

Today, the College is a medical academy with nearly 2,000 elected members and a nationally-renowned center for the medical humanities. The College draws on its world class historical medical library and medical collections to interpret for the public an historical perspective on contemporary medical issues. Last year the College mounted a major new exhibition called "When the President is the Patient." This exhibition has received international acclaim and has thrust the College into the position of leading the public discussion on the issue of presidential health.

The College's presidential health exhibit, which I have had the privilege of visiting, raises a number of troubling questions about our system for addressing presidential health issues. How, for instance, can we strike an appropriate balance between the public's right to know and the President's desire to preserve personal privacy? To what extent can we allow illness to compromise the performance of occupants of the Oval Office? Do presidents receive the best medical care available when they become ill? How can politicians appropriately address the question of presidential disability? And, what is the status of the Twenty-fifth Amendment today?

Some of the questions raised by the College's Presidential Health exhibit will be addressed during today's Forum. Before I discuss these questions, I would like to comment on the status of the Twenty-fifth Amendment and the recommendations of the Working Group on Presidential Disability.

The Twenty-fifth Amendment to the Constitution was ratified in 1967. This amendment represented a serious effort to address the issue of presidential incapacity. It provided procedures for fulfilling the duties of the presidency in the event of the removal, death, or resignation of the President, and for the filling of a vice-presidential vacancy.

Today, the Twenty-fifth Amendment provides the constitutional framework for dealing with questions of presidential succession. The Amendment was carefully studied by the Working Group on Presidential Disability. This unofficial committee of academics, lawyers, and others came together several years ago. On December 3, 1996 the Working Group issued a series of recommendations designed to address existing gaps in the Twenty-fifth Amendment.

The Working Group's recommendations include drawing a clear distinction between "impairment" and "disability," increasing the discretionary power of the White House physician, and requiring each new administration to have a medical contingency plan in place before the president-elect is inaugurated. There has been general agreement that, taken together, these recommendations constitute a step forward. Thoughtful critics, however, are concerned that the Working Group's suggestions do not go far enough.

There appears to be little controversy over the Working Group's recommendation to improve the definition of presidential "impairment" and presidential "disability." Significant concern has been expressed about increasing the discretionary power of the White House Physician and about White House medical contingency plans. Those who have expressed concern about increasing the discretionary power

of the White House Physician claim that there exists a potential conflict of interest and an opportunity for the abuse of power because the President is Commander in Chief and the White House Physician is, traditionally, a military medical officer. Critics of proposals to increase the discretionary power of the White House Physician have recommended the establishment of an independent panel of physicians who would provide a mandatory second opinion about a president's mental or physical ability to remain in office.

Medical contingency plans have become an important concern as well. Every administration since President Eisenhower's has had one. Critics of these plans note that the plans are state secrets. This means that they can be changed suddenly to enable a compromised president to remain in office without public disclosure of his or her condition. Critics also remind us that no contingency plan can cover every eventuality.

If members of the Working Group on Presidential Disability had been able to visit the College's exhibition on Presidential Health before offering their recommendations, they would have learned how past presidents—Democrats and Republicans from early to modern times—have participated in efforts to mislead Congress and the American people about the state of their health. They would also have learned how many decisions concerning the ability of an ill or injured president to remain in office have been made on the basis of political rather than medical criteria.

Like the members of the Working Group on Presidential Disability, those attending today's Forum are presented with a series of challenging questions about the integrity and quality of our current system of providing for our president's health. To help you understand and address these questions, the College has assembled four distinguished experts on the subject: Dr. George Lundberg, editor of *The Journal of the American Medical Association*; Dr. Herbert Abrams, a Professor of Radiology at Stanford University; Dr. Bert Park, a practicing neurosurgeon and author; and Dr. Hugh Evans, Professor of Pediatrics, Preventive Medicine and Community Health at the University of Medicine and Dentistry of New Jersey. Each of these physician-scholars has outstanding credentials and each brings unique knowledge to our public discussion of the issue of presidential health.

As many of you know, I have had the privilege of serving in the United States Senate on the behalf of the citizens of the State of Pennsylvania since 1980. My involvement with the issue of presidential health has spanned my entire public career—from my days on

the staff of the Warren Commission to my candidacy for the elected office of President in 1996. I remain personally and professionally interested in the outcome of today's Forum. I am specifically interested in learning whether the College of Physicians will recommend legislative action to strengthen our current system of providing for the health of the President of the United States.

As you approach the topic of presidential health, I ask you to consider the following questions:

1. Is the public best served by our current system of providing for the president's health?
2. Is the president best served by our current system of providing for presidential health?
3. Under our current system of providing for our presidents' health, can a president deceive the public about the state of his or her health?
4. Would our nation be better served if the White House Physician were required to consult with an independent panel of physicians for a mandatory second opinion when it is necessary to make judgments about a president's mental or physical ability to serve in office?

Thank you for providing me with this opportunity to share my views and questions on the important topic of presidential health. I look forward to learning your answers to these and other relevant questions raised by this forum's speakers.

When the President is the Patient

Marc S. Micozzi

Founded in 1787, the College of Physicians is the oldest medical society in the nation. Although not a matriculating college in the traditional sense, the institution seeks to educate members of the public and the medical profession. As a center for the medical humanities, the College encourages the study of history as a means of illuminating contemporary issues. With the final election of the twentieth century approaching, we felt that it was time to explore the issue of presidential health. We did so with the knowledge that, if elected, Senator Dole would have been America's oldest president. What we did not anticipate, however, was that Senator Dole would raise health issues in his race against President Clinton.

The role of health is often overlooked when we attempt to explain the character and behavior of our presidents. Andrew Jackson, respected by contemporary historians as an important president, is also seen as difficult, hot tempered, and determined to have his own way. The knowledge that Jackson was in physical pain every day of his presidency may require a reinterpretation of his behavior. Similarly, we do not recognize the profound sense in which Theodore Roosevelt was truly a self-made man. Endowed with wealth but a frail body, he worked ceaselessly to develop the powerful physique he desired. Roosevelt was confident that he could master the job of president because he had mastered himself.

The College's exhibition "When the President is the Patient" illustrated several important themes. The exhibit showed that the president's health has been a significant concern from the beginning of our nation's history. Early in his first term, George Washington developed pneumonia and nearly died. Thomas Jefferson even acknowledged this possibility in a letter to a friend. Washington's Vice-President, John Adams, was a brilliant man and a great patriot, but he was neither a military hero nor blessed with a conciliatory nature. It might have been difficult for Adams to have held the young nation together had Washington succumbed to his illness.

The College's exhibition and lecture series emphasized how deceiving appearances can be. Campaigning during the second term of

an elderly president, John Kennedy announced that he was the person to "get the country moving again." Although Kennedy appeared to be the picture of health, he actually suffered from Addison's disease, an incurable but controllable adrenal condition. Ironically, Kennedy attempted to use health issues against his chief rival for the Democratic nomination, Lyndon B. Johnson, who had suffered a heart attack in 1953. Johnson's camp responded by suggesting that Kennedy was afflicted with Addison's disease. Kennedy, his family, and his physician adamantly denied that he had ever had the disease. This denial was later justified on the basis of a medical technicality. Kennedy had primary adrenal insufficiency, whereas Addison's original description of adrenal failure was based on secondary destruction due to tuberculosis. As we know, Kennedy went on to win the election in 1960 by a very small margin. Had voters known that Kennedy was not as healthy as he appeared, he might have lost the election.

Fifty years earlier, voters had chosen Woodrow Wilson, hoping that he would make the White House an engine of reform. Wilson's commitment was genuine but his health was frail. His personal physician, Cary Grayson, made sure that Wilson's schedule included plenty of time for rest. This arrangement worked well during Wilson's first term but was imperiled by the exigencies of a world war. The serious challenges confronting the president permitted him few opportunities for relaxation. Grayson advised Wilson against the ill-fated speaking tour promoting the League of Nations, but the President ignored him. The accelerated progression of the president's cerebrovascular disease affected his cognition. During his final eighteen months of office the president could rarely focus on anything for more than ten minutes. In 1921, a shattered Wilson passed the baton to another seriously ill president, Warren G. Harding.

Warren Harding personified the pleasant aspects of small-town America. An Ohio newspaper publisher by trade, Harding was a "joiner" who played the trumpet and enjoyed a good game of cards. Although he was considered a dark horse throughout his campaign, he looked presidential and offended no one. Unfortunately, Harding epitomized the prosperity of the 1920s in another way—he suffered from heart disease. Even by the standards of the time, the care he received was nothing short of shameful. Harding's White House physician, Dr. Charles Sawyer, never recognized Harding's blue lips and shortness of breath as symptoms of heart disease. In 1923 President Harding decided that he wanted to visit Alaska. Rather than discourage him from making the trip, Sawyer encouraged Harding

to pad his schedule with speeches, parades, and other opportunities for publicity. When Harding became seriously ill, Dr. Sawyer told the press that he was suffering from food poisoning. After Harding's death, Sawyer maintained that the President had died from a stroke and not from heart disease.

The College's program on presidential health exposed the myth that our presidents have always received the best medical care possible. In many cases, ordinary citizens have received far better care than their president. This is true, in part, because politics become an important factor when the president is the patient. There may, for instance, be pressure to deny or minimize an illness instead of seeking appropriate treatment. From a physician's perspective, it may be very intimidating to treat the President of the United States and Chief Commanding Officer of the Armed Forces. In addition, the pressures and commitments of presidential office may make it difficult for doctors to demand the range of tests and procedures that might provide them with a truly thorough understanding of the president's health.

The College program focused on some interesting historical material. Medically speaking, a shooting victim who lingers for eighty days is likely to survive. Had President James Garfield been shot in 1891 instead of 1881, he probably would have lived. New theories about hygiene and infection were circulating during the 1880s but had not achieved widespread acceptance. Without the benefits of x-ray technology, invented in 1895, doctors repeatedly probed Garfield's wound with unwashed fingers trying to locate the bullet. It is truly ironic that their attempts to save Garfield's life were probably what killed him.

It may seem surprising to us, today, that the United States could survive without a competent president for eighty days. This arrangement was, in part, feasible because the United States was not yet a world power. In addition, Congress was not in session at the time of the shooting and there were no major domestic crises that demanded attention during this period. For much of our history, it was possible for a president to disappear from public view for weeks if not months at a time. The transformation of the president's role is further emphasized when we realize that one of Garfield's successors, Grover Cleveland, used to answer the White House telephone himself after the lone operator went home in the evening.

President William McKinley probably received sub-optimal care when he was shot at the Pan-American Exposition in 1901. Dr. Roswell Park, the most prominent surgeon in Buffalo, was out of

town, so Dr. Mathew Mann, a gynecological surgeon, was chosen to operate on the president. McKinley was taken to a small hospital on the Exposition grounds. The facility was ill equipped and the lighting was so poor that one of the members of the medical team tried to capture the rays of the setting sun with a hand mirror in order to reflect them into the president's open abdomen. Dr. Mann ultimately abandoned his unsuccessful search for the bullet and the president died seven days later.

Franklin D. Roosevelt was another victim of medical mismanagement. He came into office partially paralyzed by polio and suffering from a chronic sinus condition. Because of the latter trouble, a military ear, nose, and throat specialist, Vice-Admiral Ross McIntire, was selected to care for the president. This arrangement may have worked well at first but by 1944 the president was gravely ill from the effects of hypertension and heart disease. McIntire ignored these developments. It was Roosevelt's daughter, Anna, who eventually insisted that a cardiologist be consulted. When Dr. Howard Bruenn of the United States Navy evaluated Roosevelt, he was shocked. He made several recommendations, including prolonged bed rest. McIntire argued that this was not possible in light of Roosevelt's responsibilities. McIntire continued to serve as the president's official physician, but in reality it was Bruenn who supervised the president's care from then on. Publicly, McIntire continued to insist that Roosevelt was merely tired or suffering from bronchitis. Moreover, it is generally believed that in an effort to hide his mistakes, McIntire is thought to have destroyed a considerable portion of Roosevelt's health records.

Many members of the general public believe that cover-ups are a recent development. The College's exhibition and lecture series showed that this is not the case. For many years, Chester Arthur's motives remained a mystery. He was a machine politician who became a staunch advocate of the civil service by the time he joined Garfield as second in command on the presidential ballot. Arthur achieved little during his time in office. He also walked away from the opportunity to serve a second term as president. Today we know that Arthur suffered from Bright's disease, a debilitating kidney disorder. As a result he did not feel that he had the energy to be the kind of president he wanted to be. He did not run for a second term because he did not feel that he could survive it. Yet when the *New York Herald* published an article suggesting that Arthur had Bright's disease, a spokesman for Arthur denounced the report as "pure fiction." The press retreated and Arthur's secret did not become public

knowledge until twenty-five years after his death. While individual circumstances differed, it is clear that there were extensive health cover-ups in the White House during the administrations of Grover Cleveland, Woodrow Wilson, Warren Harding, and Franklin D. Roosevelt, among others.

The situations described above reveal significant problems with the provision of presidential health care. In addition, there appears to be a built-in conflict of interest when a military physician becomes responsible for the health of the Commander-in-Chief. Although this arrangement has become traditional in our country, there is no legal or constitutional basis for it. Will a military physician serve the public interest, the president, or the chain of commanding officers? The Oath of Hippocrates, followed by most physicians, puts the interests of the patient above all else. Military officers, on the other hand, swear to protect a document, the United States Constitution, not any one person. How will a military physician decide his or her priorities? While I have no power to foretell the future, I have examined the historical record. It is clear that Cary Grayson and Ross McIntire did not provide or arrange to provide the best medical care possible. Their willingness to participate in health cover-ups raises concerns about responses in the future. The public and the medical community have compelling grounds for reevaluating the current system before another problem occurs, a problem that could be perilous for a president, the nation, or both.

President Lincoln's Fatal Wound: An Experimental Study

John K. Lattimer

The Stage is Set

President Abraham Lincoln was a tough, resilient frontiersman. In his youth he survived exposure to malaria and typhoid. He suffered from migraine-like headaches and more than once had to overcome profound depressions following major blows such as the rupture of his engagement to Mary Todd and later the death of their son William. Although the stress of directing a war during which hundreds of thousands of young men died must have taken an additional toll, Lincoln continued to present a very healthy and muscular impression. Shortly before he was killed, Lincoln picked up an axe at the Old Soldiers' Home he often visited and put on a display of wood chopping that amazed onlookers. He finished by holding the heavy axe at shoulder height, arm straight out, striking the pose that woodchoppers used to demonstrate competitive strength.

It took a large bullet, fired at pointblank range, to kill Lincoln. Only five days after Confederate forces surrendered, President Lincoln lost his life. His victorious general, Ulysses Grant, had arrived in Washington and had delivered a message of victory to Congress. The capital city was ablaze with lights and festivities. A newspaper announced that the Grants would accompany President Lincoln and his family to a celebratory performance at Ford's Theater. The well-known actress Laura Keene and her company were presenting Tom Taylor's comedy, *Our American Cousin*.

These plans came to the attention of John Wilkes Booth, an actor and ardent Confederate sympathizer. Previously, Booth had hoped to kidnap President Lincoln in order to pressure the United States government into exchanging prisoners with the Confederacy. Now, Booth decided to kill Lincoln. He hoped to create enough panic within the federal government that Lee would be inspired to "unsurrender."

As a frequent performer at Ford's Theater, Booth easily entered the building. He looked over the presidential box and determined that the lock was weak and would yield to vigorous pressure from the outside. He also made a channel in the plaster by the door for a bar that would prevent anyone else from entering after him. Later in the day, Booth contacted a fellow conspirator, Lewis Powell Payne, and urged him to assassinate Secretary of State William Seward who was, at the time, confined to bed with injuries from a carriage accident. Another conspirator, George Atzerodt, was assigned the duty of killing Vice-President Andrew Johnson at his hotel.

The dual appearance of the president and the general was abruptly cancelled when Mrs. Grant (who disliked Mrs. Lincoln) persuaded her husband to leave Washington in order to visit their children in New Jersey. This deprived the Lincolns of the protection of Grant's very capable bodyguards. Instead, they were accompanied by Senator Harris's daughter, Clara Harris, and her fiancé, Major Henry Rathbone. The group arrived at the theater after the play had started. The crowd that had assembled to see Grant had dispersed. The Lincolns and their guests ascended a spiral staircase on the left side of the theater lobby and made their way around the back of the dress circle to the presidential box on the right-hand side of the theater. The orchestra leader saw them come in, stopped the performance, and played "Hail to the Chief." Lincoln bowed several times to prolonged, boisterous applause before the production resumed.

At 10:15, Booth rode up to the back of the theater and entrusted his horse to a young man who was a stage-hand. He instructed the boy to remain ready as he would be coming out soon and in a great hurry. Booth then used a passageway beneath the stage to reach the tavern next door where he had a drink, looked at his watch, and said, to no one in particular, that, by the next morning, "They would all know who he was all right."[1] He then reentered the theater through the lobby, ascended the same spiral staircase, and approached the presidential box. Several witnesses have said that he took a card out of his wallet at this time, probably intending to persuade any guard that he was a legitimate member of the theatrical group. There was, however, no guard at the door, as this man had left his post to get a better view of the stage. Booth pushed his way into the box and used his bar to secure the door behind him. He then peered through

---

[1]This remark has been attributed to the tavern keeper, Peter Taltavell. See Jim Bishop, *The Day Lincoln Was Shot* (New York: Harper & Row, 1955).

a peephole in the box's inner door to confirm that his victim was seated as he expected. When Booth stepped through the inner door he brought his pistol as close as possible to Lincoln's head, knowing how inaccurate a short-barreled, nineteenth-century derringer pistol could be. A theatergoer, sitting across from the President, saw Booth enter and wondered whether he was watching Grant arriving late so as to avoid attention.[2] He later recalled seeing Lincoln twist his head sharply to the left just before the pistol flashed. He thought Lincoln was looking down into the orchestra. Booth's bullet entered the back of President Lincoln's head, one-inch to the left of midline, even though Booth had probably approached the president from the right.

Major Rathbone responded to the gunshot by jumping up and grappling with Booth. Booth quickly produced a sharpened hunting knife and slashed the Major's upper arm, creating a long and bloody gash. Major Rathbone staggered back and Mrs. Lincoln began to scream. Booth vaulted over the edge of the theater box. He made a spectacular leap to the brightly-lit stage below, black coat flying, spurs shining, knife flashing. However, the small catch of a spur on the box's bunting may have caused him to land off balance, the impact fracturing his fibula about four inches above his ankle joint. Booth paused long enough to shout "Sic Semper Tyrannis" (So always, tyrants). He swung his knife at actors in his way as he moved towards the back of the theater where his horse was being held. Some witnesses have described him limping across the stage; others do not recall this difficulty. It has also been said that he had some trouble mounting his horse, but, being generally agile, he was soon astride. He set off quickly, along a pre-planned route, towards the Navy Yard Bridge and the safety of the Maryland countryside. Within a few hours Paine's accomplice, David Herold, caught up with him and the two rode to John Lloyd's tavern in Surratsville, where they picked up a Spencer carbine that Booth had stored there. From there they went to Samuel Mudd, a Confederate sympathizer, for help with Booth's leg. Booth had met Dr. Mudd previously while buying horses for his group of conspirators. On this occasion, however, he had worn a false mustache and concealed his identity with the skill of a professional actor. Now Booth and Herold awakened Dr. Mudd, saying that Booth's horse had fallen on him and broken his leg. Mudd constructed a lightweight reinforced splint from an

---

[2]James P. Ferguson, April 15, 1865, National Archives, Microfilm M-599, reel 4, frame 339.

old hat-box of his wife's. After the pair left, Mudd asked his brother to inform federal officials of Booth's visit and let them know that they were searching for a man with a broken leg. Dr. Mudd was subsequently arrested. His actions earned him a dubious place in the popular lexicon through the phrase "Your name will be Mudd." Ten days later Booth was fatally shot in a blazing barn in Virginia.

Lincoln's Fatal Injury

At the theater, in the president's box, Mrs. Lincoln called out for a doctor. She supported the president's body and prevented him from falling to the floor. He was already unconscious and would never again regain consciousness. Major Rathbone, meanwhile, persuaded the frantic crowd outside the box to stop pushing on the outer door so that he could dislodge Booth's barricade. Among the first to enter was a young Army surgeon from New York, Dr. Charles Leale. In addition to war-time experience with head injuries, various sources suggest that Leale had received special instruction on the subject of brain injury from the well-known New York physicians Austin Flint, Sr. (1812–1886) and Austin Flint, Jr. (1836–1915).[3] Leale later said that it was almost as if his education had been designed to prepare him for the situation he was about to encounter.[4] He found the president unconscious, without appreciable breath or pulse. He laid Lincoln on the floor by the presidential rocking chair. In later years, Leale reported providing mouth to mouth ventilation and closed-chest compression, hoping to restart the president's heart.[5]

The president did begin to breathe again and an appreciable pulse returned. Because Leale had seen Booth run across the stage waving a knife, he began to look for a stab wound. He requested a pocketknife and slit Lincoln's collar and shirt to search for an incision, but found none. When he noticed that one of Lincoln's pupils was larger than the other, Leale became concerned about the possibility of a head injury. He ran his fingers through Lincoln's hair and discovered a bullet hole on the left, towards the back of Lincoln's head, near the base of the skull. Blood from the wound had seeped

---

[3]C.A. Leale, "Lincoln's Last Hours," Address delivered before the Commandry of the State of New York Military Order of the Loyal Legion, 1909. Document in the possession of Helen Leale Harper Jr., Pelham, New York.
[4]Ibid.
[5]Ibid.

onto the President's shoulder and collar. After Dr. Leale dislodged a clot at the bullet hole, Lincoln's breathing and heart rate seemed to improve. Several times over the next few hours, Leale dislodged a clot from the bullet hole and each time Lincoln's vital signs appeared to improve. Several witnesses, including Dr. C.S. Taft, remarked upon these improvements.[6]

On at least two occasions, Leale and Taft tried to give the President a small amount of brandy. The first time they thought Lincoln swallowed it, the second time they recognized that he had not. There is no record of any response suggesting that the President aspirated (took into his lungs) any of the liquid. With chest x-rays forty years in the future, it is unlikely that concern over aspiration pneumonia or pneumonitis would have prevented Leale or other physicians from giving oral fluids or medications to an unconscious patient. It was also acceptable for Leale to probe the wound with unsterile fingers. He knew that not all pistol balls entered the skull and that some lodged beneath the scalp. He also knew that the bullet would have arrived with a burning patch of greasy cloth or leather that would have to be removed if it had not entered the skull. Examining the president's skull with unsterile hands would not have elicited criticism in a culture that was only beginning to understand the role of microorganisms in the spread of disease. Moreover, Leale's actions apparently benefited the president, whose pulse and respiration improved each time Leale removed blood and necrotic brain tissue from the bullet hole.

In a recent issue of the *American Heritage Magazine*, Richard Fraser suggested that Dr. Charles Leale was responsible for converting a "significant" brain injury into a fatal one by probing the site with unclean hands.[7] Our experimental study of Lincoln's injury demonstrated that it is not possible to insert even the tip of an adult finger through the skull hole created by the type of .41 caliber derringer Booth used. The hole is far too small and the margins are razor sharp.

Leale probed the bullet hole in the back of Lincoln's head in order to establish whether the bullet was still under the skin, but found that it had entered the skull. The skin around the bullet hole was engorged due to the vascularity of the scalp. A smooth tunnel

---

[6]C.S. Taft, "The Last Hours of Abraham Lincoln," *Medical and Surgical Reporter*, 12 (1865), pp. 452–454.

[7]Fraser, R.A.R., "How Did Lincoln Die?" *American Heritage Magazine*, Feb./March (1995), pp. 63–70.

thus led to the bullet hole in Lincoln's skull. Leale's repeated written descriptions of the lining of the track as "perfectly smooth" suggests that he did not put his finger through the hole in Lincoln's skull or he would have found it very sharp, particularly with ungloved hands.[8]

In addition to caring for the president as described above, Leale argued against transporting him to the White House. He did not believe that Lincoln could survive a carriage ride over poorly paved streets. The president, however, could not remain at Ford's. Theaters were often regarded as immoral enterprises during the nineteenth century and the nation's leader could not be allowed to die in such undignified circumstances. A compromise was reached and Lincoln was moved to the rooming house across the street. There, in a back bedroom, Lincoln was laid diagonally across a bed with his shoulders raised on pillows to accommodate his height. When the towels beneath him became soaked with blood they were thrown out the window and replaced with fresh ones. By morning, a pile of these blood-soaked towels was found in the alleyway below.

Towards one A.M., Lincoln experienced a generalized spasm and his forearms pronated. From then on, his pupils remained dilated; they no longer contracted when light was shone at them.

More than three hours after the president was shot, the Surgeon-General of the United States, Brigadier General J.K. Barnes, arrived and took over responsibility for the case. Barnes used porcelain-tipped Nelaton probes to examine the President's skull wound. The president at this time was breathing independently but had assumed the decerebrate posture associated with irreversible brain damage.

As dawn approached Lincoln's vital signs deteriorated further. Towards 5:30 A.M. his wound stopped bleeding and his respirations and pulse became progressively weaker. Finally, at 7:22 A.M., Lincoln's breathing and heart beat stopped completely. Reverend Phineas Gurley gave a stirring eulogy and Secretary of War Edwin Stanton is said to have declared that "Now he belongs to the ages."[9]

---

[8]C.A. Leale, "Lincoln's Last Hours," Address delivered before the Commandry of the State of New York Military Order of the Loyal Legion, 1909. Document in the possession of Helen Leale Harper Jr., Pelham, New York.

[9]These words are traditionally attributed to Stanton and they appear on Lincoln's tombstone in Springfield, Illinois. However, contemporary accounts of the president's death do not mention Stanton speaking them. They were reported by Lincoln's private secretaries, Nicolay and Hay, in *Century Magazine* (January, 1890), p. 436.

Although Dr. Barnes had directed the final hours of Lincoln's care, it was Leale who weighted the president's eyelids with coins from his pocket and then used his handkerchief to bind up the president's sagging jaw until rigor mortis set in.

Assistant Surgeon with the Armed Forces Institute of Pathology, J. Janvier Woodward was on duty at the Army Medical Museum when the president's body arrived. With the assistance of another Army doctor, Assistant Surgeon Edward Curtis, Woodward performed a post mortem study of the president's head. His brief, handwritten report is reprinted on the following page.

Drs. Taft and Barnes offered alternatives to the bullet trajectory described by Woodward.[10,11] While Woodward wrote that the ball had traversed the left lateral ventricle and had come to rest near the left eye socket, Taft claimed that the bullet had eventually lodged behind the right eye socket. In order to reach this low position the bullet would have had to cross the brain stem. Had it taken this route it is unlikely that Lincoln would have lived more than a few minutes. Dr. Barnes thought that the bullet had come to rest above the right eye. This route would have carried the bullet across the midline of the brain but not through critical areas in the brainstem. Thus, Lincoln might have remained alive—as he did—for a few hours, until the swelling of his brain caused it to herniate through the foramen magnum, eventually killing him.

Traumatic Brain Injury After Gunshot

Trauma experts have found that many people who sustain gunshot wounds to the brain die in the field.[12] Only a small number live long enough to reach a hospital. Those who become immediately unconscious and remain so usually die, as did both Presidents Lincoln

---

[10]C.S. Taft, "Last Hours of Abraham Lincoln," *Medical and Surgical Reporter* 12 (1865), pp. 452–454.

[11]J.K. Barnes testimony in the Trial of John H. Surrat, Washington, D.C., House Report No. 7, Fortieth Congress, 1867, vol. 1.

[12]Further corroboration of the poor outcomes of gunshot injuries to the head can be found in Graham, Thomas, et al., "Civilian Gunshot Wounds to the Head: A Prospective Study," *Neurosurgery* 27 (1990), pp. 696–700, and Howard Kaufman, "Gunshot Wounds to the Head: A Perspective," *Neurosurgery* 18 (1986), pp. 689–695, as well as elsewhere.

Surgeon General's Office
Washington City, DC, April 15, 1865
Brigadier General, J.K. Barnes, Surgeon General, U.S.A.

General:

I have the honor to report that in obedience to your orders and aided by Assistant Surgeon E. Curtis, U.S.A., I made in your presence at 12:00 this morning an autopsy on the body of President Abraham Lincoln, with the following results. The eyelids and surrounding parts of the face were greatly ecchymosed and the eyes somewhat protuberant from effusion of blood into the orbits.

There was a gunshot wound of the head, around which the scalp was greatly thickened by hemorrhage into its tissues. The ball entered through the occipital bone about one inch to the left of the median line and just above the left lateral sinus, which it opened. It then penetrated the dura mater, passed through the left posterior lobe of the cerebrum, entered the left lateral ventricle and lodged in the white matter of the cerebrum just above the anterior portion of the left corpus striatum, where it was found. The wound in the occipital bone was quite smooth, circular in shape, with beveled edges; the opening through the internal table being larger than that through the external table. The track of the ball was full of clotted blood and contained several little fragments of bone with a small piece of the ball near its external orifice. The brain around the track was pultaceous and livid from capillary hemorrhage into its substance. The ventricles of the brain were full of clotted blood. A thick clot beneath the dura-mater coated the right cerebral lobe. There was a smaller clot under the dura-mater on the left side. But little blood was found at the base of the brain. Both the orbital plates of the frontal bone were fractured and the fragments pushed upward towards the brain. The dura-mater over these fractures was uninjured. The orbits were gorged with blood.

I have the honor of being very respectfully your obedient servant.

E.J.J. WOODWARD, ASSISTANT SURGEON, U.S.A.

A TRUE COPY, GEORGE A. OTIS, ASSISTANT SURGEON, U.S.A.

The wording above corresponds to J.J. Woodward, "Report of the Autopsy of President Lincoln, April 15, 1865." The original is at the Surgeon General's Office, Washington, D.C.

and Kennedy. Survivors will experience varying degrees of neurological impairment depending upon which structures have been damaged. Patients may be paralyzed, blinded, or have cognitive deficits. If the bullet does not hit any critical areas in the brain, a person might survive with minimal neurologic damage, but such cases are exceedingly rare. Similar observations have been made by physicians who treated the vast number of casualties following the attack on the German-held beaches of Normandy during World War II.[13] It should be noted that Leale anticipated a fatal outcome for Lincoln when he discovered that the ball had entered Lincoln's brain. Nearly one hundred years later, Dr. Lawrence Pool reached the same conclusions when Robert Kennedy was shot.

As part of his argument that Lincoln's injury need not have been fatal, Richard Fraser, in his *American Heritage* article, cites a handful of cases from the archives of New York Hospital describing patients who survived gunshot wounds to the head during the 1860s.[14] Patients who survived the comparably slow and dangerous transfer to a hospital during the nineteenth century are an even less representative subset than the minority of patients who survive EMS transport today. Their outcomes are unlikely to reflect the actual mortality of persons who receive gunshot wounds to the head in either century. Richard Fraser also claims that during the Civil War soldiers as well as civilians survived their brain injuries more often than not.[15] These estimates contradict the actual statistics compiled by the War Department and listed in Volume I of *The Medical and Surgical History of the War of the Rebellion.* In a series of 4,350 gunshot wounds to the cranium, missiles penetrated the brain 486 times. Four hundred and two of these 486 patients (over 80%) died.[16] The War Department's statistics reveal an interesting secondary phenomenon. If the missile went completely through the brain and exited the other side of the skull, the patients tended to have somewhat better outcomes than if the missile stayed inside the brain, as it did in Lincoln's case.[17] When bullets were

---

[13]James Hughes, personal communication, 1995.

[14]Fraser, R.A.R., "How Did Lincoln Die?" *American Heritage Magazine*, Feb./March (1995), p. 69, col. 2.

[15]Fraser, R.A.R., "How Did Lincoln Die?" *American Heritage Magazine*, Feb./March (1995), p. 70, col. 1.

[16]G.A. Otis, *Medical and Surgical History of the War of the Rebellion* (Washington, D.C., 1875), vol. 1, pp. 307–308.

[17]G.A. Otis, *Medical and Surgical History of the War of the Rebellion* (Washington, D.C., 1875), vol. 1, p. 308.

removed from the brains of 175 Civil War soldiers who had been shot in the head, ninety-two (or 53%) survived.[18]

Napoleon's surgeons already knew that missiles entering soft tissue create a cavity two or three times larger than the penetrating object. Napoleon's chief-surgeon, Baron Dominique Jean Larrey (1766–1842) demonstrated this phenomenon by using an air gun.[19] When a missile is made to rotate by "rifling" the barrel of the gun or if it is given more velocity, the size of the cavity becomes even larger. Cavitation in the delicate, gelatinous substance of brain tissue is more extensive than in solid tissues. In his article in *American Heritage Magazine*, Fraser repeatedly states that cavitation did not occur in Lincoln's case due to the low velocity of the ball.[20] Although low-velocity missiles produce less cavitation in solid tissue, this effect does not apply to the delicate tissue of the brain where cavitation is almost inevitable. Brain tissue damaged by cavitation never recovers fully and the bodily functions controlled by injured parts of the brain may never recover either. These circumstances differ from injuries to tissues in other parts of the body, which can heal and resume their functions. Cavitation in the brain is far more pernicious.

In addition to the cavitation from the missile itself, secondary missiles created by derringer bullets are enormously destructive. First of all, in Lincoln's case, a piece of the ball had sheared off and therefore the ball was no longer round. It had become a flattened disk, fourteen by seven millimeters, with a very sharp side where the edge of Lincoln's skull had sliced off the lead fragment. This fragment was found in Lincoln's brain. Derringers, such as the one Booth used, have to be fired at pointblank range but their barrels are designed to spin the ball, creating a highly destructive impact. Booth's gun also had an additional chamber for extra powder that made it more lethal than the ordinary pistols of the time. A greased patch of cloth or thin leather had to be used with the bullet in order to prevent the loose powder from falling out, surrounding the bullet, or filling the rifling grooves. Such patches ignited during firing and caused considerable damage on their own. Our experimental

---

[18]G.A. Otis, *Medical and Surgical History of the War of the Rebellion* (Washington, D.C., 1875), vol. 1, p. 308.

[19]Baron Dominique Jean Larrey, *Napoleon's Surgeon-in-Chief: Memoires et Campagnes* (Paris: Edition Remanence, 1983).

[20]Fraser, R.A.R., "How Did Lincoln Die?" *American Heritage Magazine*, Feb./March (1995), p. 68, col 2.

model, described below, showed that these patches frequently lodged inside the brain. In these cases, the brain tissue was severely burned as it had, in effect, put out the smoldering patch. Patches and cavities were also visible in some of the x-ray images we produced as part of our research on Lincoln's brain injury.

Even Fraser acknowledges that secondary missiles, created when energy is transferred to bone fragments, chisel out a cavity larger than the original bullet because these fragments continue to tunnel through brain tissue. We documented this phenomenon during the experiments we performed with skulls packed with fresh animal brains. Nonetheless, Fraser contends that "there were no secondary missiles in Lincoln's case."[21] In actuality, there were multiple secondary missiles in Lincoln's brain.

Causes for Error

When I first started studying Lincoln's assassination over thirty years ago, I repeated the mistakes made by others. I accepted the prevailing opinion that Dr. Leale had inserted the entire length of his left fifth finger into the hole in Lincoln's skull, probing his brain. I repeated this lore without thinking much about it and certainly without doing any experimental investigation of my own. I also wrote that the fragment of metal that was sheared off the bullet was almost the size of a modern dime.[22] Only after I had published these remarks did it become clear to me that they were probably wrong. I realized that I would not have inserted my finger blindly through the track in an engorged scalp into the skull hole because the bony margins of the hole would be razor sharp. No wartime surgeon would have done this, including Dr. Leale.

I resolved to do some experimental investigation of derringer wounds in case they were different in some way. I had performed this type of medical work for the United States Army during World War II and again when I investigated the shooting of John F. Kennedy in 1963.[23] I had access to appropriate facilities and an organized team of highly competent research associates. In February

---

[21]Fraser, R.A.R., "How Did Lincoln Die?" *American Heritage Magazine*, Feb./March (1995), p. 68, col 2.

[22]John K. Lattimer, "The wound that killed Lincoln," *J.A.M.A.* 187 (1964), pp. 480–489.

[23]John K. Lattimer, *Kennedy and Lincoln: Medical and Ballistic Comparisons of Their Assassinations* (New York: Harcourt, Brace, Jovanovich, 1980).

of 1995, spurred by Fraser's article in *The American Heritage Magazine* we began our investigations.

Experimental Investigations

A replica .44 caliber derringer pistol of modern steel was obtained through the generosity of the Dixie Gun Works, Union City, Tennessee. It fired .41 caliber "patched", 95 grain lead balls and could tolerate powder charges that would allow bullets to penetrate the thickest part of the back of a human skull.[24] The required charge was determined through a series of trials and ultimately eighteen grains of FFG powder was selected as the appropriate amount. Skulls, packed with animal brains in plastic bags (to simulate the dura), were prepared. Ballistic screens were used to demonstrate whether the primary and secondary missiles were rotating, tumbling, or precessing. The firing range of the New Jersey Arms Collectors Club at Allamuchy, N.J. was used as a site. The Club's president, Angus Laidlaw, an experienced muzzle-loader, provided equipment and extensive expertise. Several laboratories, the radiology department, and the audio-visual department of the Columbia-Presbyterian Medical Center participated in this research as well.

First we addressed the question of the size of the metal disk that sheared off the original bullet by the edge of the skull hole. We discovered that some of the .41 caliber balls we used were indeed flattened to the approximate size of a modern dime (17 mm) but that the actual metal disk found in Lincoln's brain appeared to be the same width as the original bullet. Its width remained 13 mm or slightly smaller than a modern dime. Even at 13 mm, the sheared piece was still a sharp, secondary missile, tumbling and cutting its way through the delicate brain substance.

We know that a piece of bone from the inner table of Lincoln's skull was pushed along in front of the bullet. This was described as a "plug" of bone by Dr. Taft.[25] Dr. Woodward, who performed the autopsy on Lincoln's brain, described "numerous small fragments of bone" along the bullet track. The largest of the fragments of bone from Lincoln's skull, preserved at the Armed Forces Institute

---

[24]Booth is known to have used a .41 ball with extra powder in his .44 derringer pistol.

[25]C.S. Taft, "The Last Hours of Abraham Lincoln," *Medical and Surgical Reporter*, 12 (1865), pp. 452–454.

of Pathology Museum, appears to be just under one inch at its widest. However, it is a broken piece. In his autopsy report, Woodward described the skull hole as "beveled", because the opening in the inner table was decidedly larger than the entrance wound. In our experimental trials, the hole in the outer table was slightly above .41 caliber; the hole in the inner table of the skull ranged from just under one inch to one and a quarter inches in diameter. It therefore follows that a fragment of bone propelled into Lincoln's brain might well have been as much as an inch at its widest point. Unfortunately, the size of the largest fragment found was not recorded. In addition, many smaller, sharp, secondary missiles are usually created from the cancellous bone between the inner and outer tables of the skull during a gunshot injury. A spinning projectile, like the bullet that killed President Lincoln, would have imparted a spin to each of these secondary bony missiles. The beveling of skull wounds, the site of entry, the size of the projectile, and the size of the defect in the inner layer provide the most dependable and consistent signs for determining the trajectory by which a missile traversed the skull.

Conclusions

When .41 caliber derringer balls were fired into skulls at approximately the angle from which Lincoln was struck, the bullets punched out a skull hole much like the one Woodward described. These holes consistently had a razor-sharp margin at the outer table and were all much too small to permit entry of even the tip of a small finger.

Not all derringer balls penetrate the skull. However, those that fail to penetrate can still crack it or loosen a cone-shaped piece on the inside. Civil War physicians felt for these extra-cranial balls by palpating the scalp wound. Bullets lodged in the scalp were surrounded by burning hair, gunpowder, and other debris that they frequently had to remove. It was for this reason that Dr. Leale inserted the little finger of his left hand into the bullet hole in the scalp and discovered that the ball had passed through the skull and into the brain. His repeated assertion that "the walls of the track made by the ball were perfectly smooth" supports the conclusion that his finger did not enter the brain.[26] If his finger had passed into the hole

[26]C.A. Leale, "Lincoln's Last Hours," Address delivered before the Commandry of the State of New York Military Order of the Loyal Legion, 1909. Document in the possession of Helen Leale Harper Jr., Pelham, New York.

over the edge of the skull, the surface would have felt rough and sharp to his bare hands.

Although Leale was only twenty-three years old, he was neither inept nor inexperienced. He had cared for large numbers of wounded soldiers and prisoners as a medical cadet with the army. He had already devised a technique for treating chest wounds that was included in the War Department's official publications.[27] He went on to become a well-respected physician in New York. He headed many medical groups and served as President of the New York County Medical Society for two terms.

While it is true that we now have modern imaging techniques, antibiotics, and life-support systems that can keep hearts and lungs functioning even after brains have died, we have made no progress that could have saved President Lincoln. One hundred years after Lincoln's assassination, Robert Kennedy, whose wound was amazingly similar, died as well. It should be clear that it was the derringer bullet that killed President Lincoln. Dr. Leale did nothing to contribute to his death. He was a capable surgeon, ably caring for a lethally wounded patient with the resources available to him.

---

[27]*Medical and Surgical Records of the Rebellion* (Washington, 1875), vol. 1, p. 502.

Resuscitating the Twenty-Fifth Amendment: Mandating a Second Opinion for the Determination of Presidential Disability

Bert E. Park

Presidential scholars have debated the reasons behind Woodrow Wilson's refusal to compromise in order to obtain congressional approval of the Versailles Peace Treaty at the end of World War I.[1] A reevaluation of the President's medical record clearly demonstrates that poor health was at least partially responsible for this outcome. Available records, particularly volumes 58 through 65 of *The Papers of Woodrow Wilson*, confirm that Wilson's thought processes and public conduct were adversely affected by progressively severe hypertension, culminating with the major stroke he suffered in 1919.[2] Recently released material supports earlier suggestions that the pervasive impact of his neurological deterioration made Wilson unable to adequately fend for himself or his cause.[3]

Wilson's impairment can be divided into two stages. For roughly twenty years up to and including his speaking tour in September of 1919, Wilson experienced the insidious onset of heart, kidney, and brain dysfunction as a result of long-standing hypertension. After his hypertensive-related stroke in early October 1919, the President's health declined precipitously. Few could deny that his mental faculties and comportment had changed significantly.

The transformation was, to some extent, predictable. Once untreated hypertension reaches an accelerated or "malignant" phase,

---

[1]John Morton Blum, *Woodrow Wilson and the Politics of Morality* (Boston: Little, Brown, and Co., 1956) and Alexander and Juliette George, *Woodrow Wilson and Colonel House* (New York: Dover Publication, 1965).

[2]Arthur S. Link, ed., *The Papers of Woodrow Wilson* (Princeton: Princeton University Press, 1966–1992), particularly volumes 58–64. Hereafter abbreviated as *WWP*.

[3]Bert E. Park, *The Impact of Illness on World Leaders* (Philadelphia: University of Pennsylvania Press, 1986), pp. 3–76 and Appendix, pp. 331–342; Edwin A. Weinstein, *Woodrow Wilson: A Medical and Psychological Biography* (Princeton: Princeton University Press, 1981).

damage to blood vessels leads to retinal hemorrhages, heart failure, renal insufficiency, and cerebral vascular accidents. A full six years before Wilson assumed office, his ophthalmologist had already documented the effects of uncontrolled hypertension. It is not surprising that thirteen additional years without treatment led to catastrophic brain injury in 1919.

Neuropsychologists would probably have identified a reduction in Wilson's "adaptive versatility" by 1918. Persons with this deficiency generally manifest a low threshold of frustration. They are prone to making unwarranted criticisms and faulty judgments and frequently complain of tiring easily. Unable to adapt to rapidly changing circumstances, they tend to concentrate on one issue at a time in order to reduce their mistakes. At the same time, they lose the ability to pay attention to details. As their emotions become less restrained, they become impervious to advice and insensitive to the concerns of others. Wilson exhibited virtually all of these characteristics by the spring of 1919 prior to his western tour.

During the accelerated phase of such cognitive decline, affected persons often become pathologic caricatures of their former selves. It is now recognized that individuals, like Wilson, who begin with more rigid adaptive patterns often exhibit greater impairment over time. For these reasons, Wilson's character and inner conflicts remain essential to understanding his behavior at the end of World War I.

Wilson's final stroke, however, was an equally important if controversial component of his presidency. It was once assumed that limited medical knowledge during the first quarter of this century precluded a precise diagnosis. This view is no longer tenable. It is now clear that the President was medically impaired and that his physician and closest associates did not acknowledge the ramifications of his disability. As a consequence, this contributed to the Senate's ultimate rejection of the Versailles Treaty and sealed the fate of the League of Nations.

The story of Wilson's presidency is a cautionary tale, to be sure, and one that most Americans continue to ignore at their own peril.[4] Despite the subsequent passage of a constitutional amendment designed to expedite both voluntary and involuntary certification of presidential disability, the haunting specter of illness in the Oval Office has not been adequately addressed. Five years before the rat-

---

[4]Arthur S. Link, "Woodrow Wilson: A Cautionary Tale," *Wake Forest Law Review* 30 (Fall 1995), pp. 585–592.

ification of the Twenty-fifth Amendment in 1967, President John F. Kennedy governed under the influence of steroids and amphetamines.[5] Ronald Reagan was medically impaired and, arguably, constitutionally disabled on three separate occasions during his Presidency, although the public was never aware of this and no formal declaration was made.[6]

Recently, two independent groups reexamined the Twenty-fifth Amendment with particular attention to Section 4, which addresses the case of a president who cannot or will not recognize his own disability.[7] The absence of medical testimony during the congressional hearings that preceded the final drafts of the amendments led to the conclusion that the current formulation was adequate, although certain deficiencies in implementation were recognized. Both groups eventually recommended an increase in the discretionary powers of the presidential physician and continued reliance on secret contingency plans. Skeptical observers, however, recognize that these recommendations permit administrations to maintain internal control over the process of declaring a president disabled. Moreover, the current protocol for recognizing presidential disability remains seriously flawed. How, for instance, can a contingency plan provide for every eventuality? What is to prevent an impaired president from altering the plan when a threat to his or her political survival emerges? Can the president's physician be dismissed, so that no one is left to monitor an afflicted president's health? Can both the public interest and the president's be adequately protected when there is no requirement for expert consultation in the event of presidential illness or injury? Would expert consultation not serve to support the presidential physician who finds himself or herself in the unenviable position of whistle-blower.

Those who are satisfied with the current system fear that changes such as required consultations with outside experts or publicly articulated contingency plans would make the presidency more not less

---

[5]Bert E. Park, *Ailing, Aging, Addicted: Studies of Compromised Leadership* (Louisville: University Press of Kentucky, 1993), pp. 168–186.

[6]Bert E. Park, *Ailing, Aging, Addicted: Studies of Compromised Leadership* (Louisville: University Press of Kentucky, 1993), pp. 209–210; Herbert L. Abrams, "*The President Has Been Shot*" (New York: W.W. Norton and Co., 1992), pp. 37–38.

[7]White Burkett Miller Center of Public Affairs at the University of Virginia and University Press of America, *Report of the Miller Center Commission on Presidential Disability and the Twenty-fifth Amendment* (1988) and *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November 10–12, 1995.

vulnerable. They argue that disclosure of pertinent medical conditions may affect a president's performance. Such health information could be amplified by the media and become a powerful if unwarranted pawn in political power games. Opponents of reform also conjure up fear of an ineffectual "medicine by committee" which might predominate if additional consultation was mandatory. Unfortunately, the jealousy with which White House insiders guard access to the president makes it unlikely that they will invite outside consultation, if not required to do so.

Acceptance of the Miller Commission and the Wake Forest recommendations ignores the frightening legacy of past experience. To begin with, one in three presidents have become seriously disabled or died while in office. Moreover, as Wilson and Roosevelt stories indicate, disability needs to be evaluated by the best available expertise. Finally, the American public has a right to know how disability will be determined. The complexity of these issues calls for a formal, institutionalized process for evaluating presidential disability. Unfortunately, the nation may need to confront a new crisis, an assassination, or a natural illness before the importance of a revised approach becomes painfully apparent. Recent candidates and the current president have recognized the public's right to know that their leader is not impaired or disabled. They have even accepted the need for independent medical corroboration of the state of the President's health.[8] More than one presidential physician, however, has indicated that they regard the participation of colleagues as an onerous oversight rather than an opportunity for complementary, supportive, and necessary assistance. Practical means of reconciling these disparate concerns is needed before the next crisis forces our hand. It is in this spirit that the following recommendations are offered:

1. Establish an Office of the Physician to the President through a joint or concurrent resolution of Congress, and strengthen this Office by inclusion of a prospectively designated team of medical consultants.
2. The organization of the Office should follow the team approach, as this structure remains one of the more successful innovations

[8]Comments of former President Jimmy Carter to the Working Group on Disability in U.S. Presidents, Carter Center, Atlanta, January 28, 1995; Interview with Robert Dole, *Washington Post*; remarks of Bill Clinton as cited in the *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November 10–12, 1995.

of contemporary medical practice. In keeping with this model, the president's physician should not only be a member of the team, but should also direct it medically and "chair" it in an administrative and a legal sense.

3. In order to establish as efficient and cohesive a team as possible, the president and the presidential physician should make the final choices from a list of nominees submitted by the American Medical Association.
4. The President's physician must, however, reserve the right to call in additional specialists of his or her choosing to assist the team.
5. The consulting body should not have the authority to report its medical findings to the public under any circumstances, but only to the vice-president and cabinet. If disagreement about a President's perceived disability persists, then the consultants could speak before a public legislative hearing, as Section Four of the Twenty-fifth Amendment already grants Congress twenty-one days to assess the President's disability in the case of disagreement between the vice-president and the cabinet.
6. The president and his or her physician will have taken oaths to uphold the Constitution. As a result, their allegiance to that document must take precedence over their relationship as commander and subordinate, not to mention as physician and patient. The president's physician would be required to disclose the consulting team's findings to the vice-president and cabinet even if commanded to conceal by the Chief-of-State/First Patient.
7. Mandating full disclosure of the medical records of presidential candidates to the public is neither necessary nor desirable. Confidentiality could be maintained by requiring candidates and their physicians to sign affidavits asserting that they are not aware of any medical conditions that could be expected to impact adversely on the individual's ability to perform the duties of the office. The receipt of federal campaign funds could become contingent on submission of such affidavits.

Ideally, any future determination of presidential inability would entail two distinct and separate steps: first, defining the degree of physical or mental impairment that is present and second, assessing whether that impairment is adversely affecting the president's occupational duties enough to be termed a "disability."[9]

---

[9]See in particular the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993).

The Miller Center Commission called for a meeting between Election Day and the inauguration "to devise plans for all medical contingencies."[10] This recommendation was followed by the Bush administration in 1989. In reality, these hypothetical contingencies are molded by political concerns regarding which medical problems warrant invoking the Twenty-fifth Amendment, who should provide the medical evaluation, and what information should remain confidential.

As our past history demonstrates, simply increasing the responsibility of the President's physician will not be adequate. Take, for example, his or her role in evaluating mental or psychological compromise. Although everyone agrees that an impaired president should not resume office until functional restoration has been certified, few are aware of the factors that limit this process. Historically, the presidential physician has had little expertise in this area of medical practice. Neurologists or psychiatrists selected after a condition develops are not only unfamiliar with the president's health until that time, but are also beholden to the administration which selected them. Their ability to arrive at an informed and unbiased judgment might be severely compromised.

The option of reconstructing the Twenty-fifth Amendment altogether, either with a new amendment or by statute, has been rejected by several parties. One constitutional scholar has already declared that there is "an insufficient historical track record to justify revision of the amendment."[11] Nor should anyone underestimate the difficulty of negotiating the inevitable legislative minefield. Former President Jimmy Carter alluded to these difficulties when he offered a solution of his own:

> Not only the president's physician, but his entire cabinet, can be dismissed in a moment . . . The president's physician, no matter how independent he or she might be, needs to have the backing of a consultative group that might be delineated by law. Let that group, with the president's physician as a spokesperson, make a mandatory report to the cabinet and the vice-president.[12]

Proponents of the current system claim that medical specialists are available at a moment's notice to evaluate the president if the

---

[10]Feerick, *Twenty-Fifth Amendment*, xxvi.
[11]Feerick, *Twenty-Fifth Amendment*, xxviii.
[12]Comments of former President Jimmy Carter, *Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995.

need arises. The public, however, needs to know how these specialists are selected. Are they the best in their fields, or merely the most visible? What is their personal relationship with the presidential physician, and what political ties might they have to the administration as a whole?

A bicameral congressional resolution could mandate the prospective selection of a group of consultants skilled in the determination of impairment. This group would then be empowered to pass judgment on the president's state of health along with the presidential physician. Only after they have arrived at their conclusions would the constitutionally designated instruments of the executive branch (the vice-president and the cabinet), or if necessary the legislative branch (Congress), be summoned to assess the effect of the president's health as stipulated in the Twenty-fifth Amendment.

This group of bi-partisan consulting specialists would be selected or appointed before an incoming administration is inaugurated. It should be charged with monitoring the president's health on a yearly basis and convening on an emergency basis if the question of inability arises. These physicians would not have the power to initiate disability proceedings against the president, much less the power to depose him. Their duties would be restricted to gathering medical facts impartially and to assisting the vice-president and cabinet in arriving at an informed decision. As such, the panel of consultants would only function as an advisory body. There would be no avenues by which these unelected persons could wrongfully usurp authority.

As impairment that affects cognitive function and, hence, decision making is the most threatening, the consulting team should include at least two neurologists, two internists with expertise in hypertension and cardiopulmonary pathology, and two psychiatrists. The seventh member would be the presidential physician. That doctor would be able to provide an overview of the president's health but would also be able to provide a deciding vote in the unlikely case of a deadlock. Either the Institute of Medicine or the American Medical Association would be appropriate bodies for nominating prospective team members before a presidential election. The nominees' credentials could then be examined in a public forum such as open hearings before House and Senate committees. The presidential physician and the incoming president would then select a team from the list of nominees.

These physicians would not be responsible for the daily care of the president, other than as consultants. They would, however, participate in his or her yearly physical evaluation for the purpose of es-

tablishing a point of reference from which they could detect subtle changes in the president's condition.

In reality, specific guidelines for evaluating impairment and consequent disability are already well established, making the above proposal all the more appealing. For almost twenty-five years, physicians have accepted the American Medical Association's *Guides to the Evaluation of Permanent Impairment* as the standard by which impairment is objectively and uniformly determined.[13] The AMA *Guides* underscore the important distinction between the terms "impairment" and "disability," and clarify who should make those determinations.[14] Clinical studies have shown that the AMA's *Guides* for determining impairment and disability have worked well when applied to executives of major corporations.[15] It would be reasonable to extend these successful guidelines to the assessment of presidential disability as covered by the Twenty-fifth Amendment.

The identification of impairment by an independent panel of consultants would also clarify the potential risks associated with a certain level of impairment, thereby assisting the vice-president in determining whether the president is able to resume his or her official duties. The vice-president would have access to non-partisan medical information in order to decide whether an impairment is adversely affecting the performance of the president's duties enough to be regarded as a disability covered by the Twenty-fifth Amendment to the Constitution.

The election of any president is, barring malfeasance in office or disability, a four-year contract. If the consultants identified an impairment that was likely to extend beyond the remainder of the president's term, the vice president and cabinet would be able to prevent any resumption of power by the president until or unless the disabled president improved. This, of course, assumes that the vice-president and cabinet will have subsequently determined that the president's capacity to meet his occupational demands is being limited by that impairment.[16]

---

[13]American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993).

[14]American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993).

[15]David S. Glass and Miriam G. Wardle, "Reliability and Validity of the American Medical Association's Guides to Ratings of Permanent Impairment," *J.A.M.A.* 248 (1982), pp. 2292–2296.

[16]For a definition of the terms impairment, disability, and handicap, see American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th Edition, 1993), p. 2.

While medical consultants can assess the risks of allowing an impaired individual to continue in his or her present employment, it is neither their right nor duty to determine the acceptability of those risks. That assessment rests on non-medical considerations and should be made by the vice-president and the cabinet. The dilemma faced by Woodrow Wilson's associates following his stroke illustrates the dangers inherent in allowing presidential physicians to let their own opinions of non-medical issues influence what should be strictly medical judgments.[17]

Some constitutional scholars, however, would have us believe that presidential inability is strictly a policy matter based on political circumstances.[18] Yet whether a vice-president would perform more capably than his disabled superior is not the salient issue. What is important is an expeditious and unbiased gathering of facts that would warrant initiating disability proceedings in the first place. The Constitution currently allows elected or appointed officials to pass judgment without mandated, impartial, medical expertise. This risks putting the political cart in front of a questionably impaired horse.

Therein lies the real problem: with or without supplementary contingency plans the Twenty-fifth Amendment does not explicitly require medical consultation.[19] Consultation is, of course, suggested, but only during the eleventh hour after disagreement over the presence of presidential impairment has emerged. In recognition of the need for prompt resolution of such controversy, the Constitution currently allows the cabinet and the vice-president four days to review the data and make a determination. If disagreement persists, then the vice president retains the powers and duties of the office, while Congress considers the matter. Congress is required to produce a decision within twenty-one days.[20] In order to expedite the determination during the first four days and avert the pitfalls of the longer process, a prospectively selected panel of independent medical consultants already familiar with the president's health must be included in the process.

Section 4 of the Twenty-fifth Amendment also fails to address the very real possibility that an impaired president might dismiss

---

[17]Bert E. Park, *The Impact of Illness*, pp. 63, 282; *Ailing, Aging, and Addicted*, pp. 110–111; Dr. Grayson's comments cited in *WWP* 64: pp. 507–513.
[18]Ruth D. Silva, *Presidential Succession* (New York: Greenwood Press, 1968), p. 92.
[19]*U.S. Constitution*, Amendment xxv, section 4.
[20]*U.S. Constitution*, Amendment xxv, section 4.

cabinet members who threaten to depose him before the situation reaches a crisis level. History has already shown that President Wilson was able to engage in such maneuvers.[21] That is why any team of consultants must be more closely linked to the vice-president than to the cabinet, as only the former cannot be forced by the president to resign. That said, even though the cabinet might be willing to declare a president disabled, a squeamish vice-president might choose to abstain. As a result, a disabled president could remain in office. Such an impasse actually occurred following the attempted assassination of President Reagan in 1981.[22] If, however, a team of consulting physicians presented information to the vice-president before the four-day deadline passed, he or she might be more inclined to act decisively.

It would be naïve to think that Congress could act swiftly in the event of disagreement between the cabinet and the vice-president. Moreover, a president could veto any statute that threatened his political survival. For this reason, concurrent congressional resolutions must prospectively define the procedural issues involved in assessing presidential impairment. Hastily assembling specialists after the fact, and only after disagreement has emerged, risks directing medical opinion along partisan lines. Such an ad hoc approach would also further delay disability proceedings, simply because the pertinent medical data would not be readily available.

Despite the obvious need for improving the management of presidential disability, there will be objections to a panel for assessing presidential impairment or disability. In addition to voicing concern over expanding bureaucracy, critics point out that similar proposals have already been evaluated and dismissed. The proposal under consideration, however, differs substantially from its predecessors. For one thing, previous panels were not prospectively selected, nor did they have a comparable composition. Nor were earlier proposals designed to function within the guidelines outlined by the Twenty-fifth Amendment. In order to appreciate the merit of the current suggestion, it is necessary to review its origins.

Dwight D. Eisenhower's brush with death in 1955 brought the limitations of Article II of the Constitution concerning presidential disability into sharp focus.[23] Confronted with suggestions for a "Pres-

---

[21]Park, *Impact of Illness*, p. 53; *Ailing, Aged, Addicted*, p.114; "Editorial," *Philadelphia Evening Public Ledger*, 2/11/1920 in *WWP* 65: 6.

[22]"Twentieth Century Task Force on the Vice Presidency: A Heartbeat Away" (1988); Abrams, "*The President Has Been Shot*," pp. 98–99.

[23]*U.S. Constitution*, article II, section 1, clause 6.

idential Disability Commission," Attorney General Herbert S. Brownell quickly dismissed any proposal that would establish "formal legal machinery" requiring physical and mental examinations during an inquest into alleged presidential disability. Brownell argued that putting the president's health "constantly on trial" would be "an affront to (his) personal dignity and degrade the office itself."[24] This narrow view ignored the evidence of past cases where the nation's best interest would have been better served had the president's health been under closer medical scrutiny. In addition, Brownell's position would question, by analogy, the Federal Aviation Association's requirement that pilots undergo independent annual medical evaluations in order to continue flying.

Brownell also warned that the deliberations of a disability commission might drag on for weeks. Worse yet, it could be undertaken in a political forum that would give rise to conflicting testimony and divide public opinion.[25] Neither argument remained valid after the ratification of the Twenty-fifth Amendment. Not only are the vice-president and the cabinet required to arrive at an opinion in four days, but Congress must act within twenty-one. Moreover, any deliberations of the medical consultants would be undertaken in secret. Their findings would only be made public after a basis for declaring the president impaired had been firmly established.

Testifying before the Senate in 1958, Charles S. Rhyne, then president of the American Bar Association, unwittingly exposed the crux of the problem while attempting to downplay the need for such a panel or commission. Rhyne noted that "historically, the real problem of presidential inability has not stemmed from a question of determining the existence of any presidential inability . . . The inability usually has been clear and undisputed."[26] Yet providing for the unusual is precisely why a prospectively chosen, non-partisan team of medical experts is necessary. Consider the subtleties involved with the determination of neurological impairment in recent presidents. How significant was the impact of large quantities of steroids and amphetamines on the thought processes of President John F.

---

[24]Herbert S. Brownell, U.S. Attorney General, opinion cited in *Special Subcommittee on Study of Presidential Inability of the House Committee on the Judiciary*, 85th Congress, First Session, 26 (1957).

[25]Herbert S. Brownell, U.S. Attorney General, opinion cited in *Special Subcommittee on Study of Presidential Inability of the House Committee on the Judiciary*, 85th Congress, First Session, 26 (1957).

[26]Presidential Inability: Hearings Before the Senate Judiciary Sub-Committee on Constitutional Amendments, 85th Congress, 2nd Session, 194 (1958).

Kennedy?[27] How much did Ronald Reagan's performance after surgery in 1981 and 1985 reflect lingering post-anesthetic and narcotic effects, enhanced by his age?[28] What degree of cognitive impairment did Reagan manifest during his last term as he moved towards his current diagnosis of Alzheimer's disease.[29] These troubling questions involve borderline cases of inability that no vice-president, cabinet member, White House staff member, or even presidential physician would prudently assess alone.

Despite these glaring shortcomings, this is how matters have stood since the ratification of the Twenty-fifth Amendment in 1967. Since any determination of presidential disability begins with the identification of physical or mental impairment, it has been very unfortunate that the role of the presidential physician has been rarely mentioned in Senate or House committee hearings. This absence is one reason why the Miller Center and Wake Forest study groups independently recommended greater involvement on the part of the presidential physician. These groups, however, limited their recommendations to reinforcing the Twenty-fifth Amendment and supporting secret contingency plans in case presidential inability occurred. Their unenforceable suggestions that the president's physician should be consulted and given more discretionary power, and that the White House staff "should not try to govern by itself, [but should] deal with the public in an open and honest manner," were primarily a confirmation of the existing approach with its evident limitations.[30] In reality, the implementation of any process to certify presidential disability has relied not so much on the presidential physician as on the willingness of the president's staff to invoke something as serious as the Twenty-fifth Amendment when they deem it necessary.

Undoubtedly, political considerations often dictate against invoking the Twenty-fifth Amendment. Yet consider the cynic's view for the moment. Under the present arrangement, can we be certain that even the most conscientious presidential physician will be able to recognize the occurrence of subtle impairment? How do we com-

---

[27]Park, *Ailing, Aging, Addicted*, pp. 168–186.

[28]Park, *Ailing, Aging, Addicted*, pp. 216–218.

[29]Bettina Boxall and Deborah Schoch, "Reagan Says He Is in Early Stages of Alzheimer's," *Los Angeles Times*, November 6, 1994.

[30]*Transactions of the Working Group on Disability in U.S. Presidents*, Carter Center, Atlanta, GA, January 26–28, 1995 and Wake Forest University, Winston-Salem, November 10–12, 1995, as quoted in Feerick, *The Twenty-Fifth Amendment*, xxi.

bat the inherent tendency among staff members to ride out the storm during what might be perceived as a temporary illness? And what of those with an authoritarian bent—the Haigs, Reagans, and Bakers of the future—who will presume to call the shots in the president's absence? Regardless of the pecking order that evolves (or the contingency plan in place), the involved parties will probably attempt to make the best of a bad situation by presenting a unified and optimistic front to the media. A president's inner circle is geared to respond pragmatically to any crisis that presents itself. Yet the president's unanticipated absence, particularly if it entails a serious illness whose duration is uncertain, presents its share of problems. Not only do staff appointees lack the necessary expertise to judge the seriousness or duration of their superior's disability, but they also have no constitutional mandate guiding their actions.

Despite the troubling nature of the historical record, some critics remain opposed to the involvement of independent, prospectively selected physicians. Spokespersons for the media argue that they could not help but expose the deliberations of any such committee.[31] In reality, members of a medical team functioning as consultants would have professional and ethical obligations regarding confidentiality. No revelations would be forthcoming unless impairment affecting the performance of presidential duties had been identified and agreed upon.

A panel of consultants should not be dismissed because it resembles "medicine by committee," any more than the input of consultants should be rejected in the care of general patients. Furthermore, President Jimmy Carter and at least one recent presidential physician have publicly supported a team approach, both for providing care and for determining any physical or mental impairment that could result in a subsequent disability.[32]

Finally, the suggestion that presidential disability could be arbitrarily determined by a close vote ignores the traditional and vital role consultants play. The very fact that medical experts other than the presidential physician have examined the pertinent data and produced a collective opinion (including a "minority" report if necessary) will at least insure that the matter has been given careful scrutiny. In the final analysis, the American public cannot afford to

---

[31]Thomas Wicker, remarks at Working Group, Atlanta, January 28, 1995.

[32]Jimmy Carter and Larry Mohr, respectively, remarks at Working Group, Atlanta, January 28, 1995.

leave such delicate medical judgments to the presidential physician alone, much less to White House legal advisors, staff appointees, or similar personnel.

The Twenty-fifth Amendment does not provide adequate definitions of terms such as "inability" and "unable." While such ambiguity may be in keeping with the general style of the Constitution, it serves little purpose now that these terms have been clarified and precise definitions have been accepted by doctors, insurance companies, judges, and employers. Moreover, simply relying on prearranged contingency plans to specify when the Amendment should be invoked not only risks failing to provide for all eventualities; such contingency plans might prove to be too binding and narrowly tailored.[33]

There remains, then, a compelling need to be more specific with regard to what presidential impairment is and who determines it. Any measure which is ultimately adopted, however, must not be so specific as to define disability within a political context or attempt to identify all contingencies in advance. The first step in this process, rather, should be the passage of a concurrent resolution by Congress that designates the composition of a consulting body and specifies the method and prospective timing of its selection. Not only will such medical expertise strengthen the position of the presidential physician, it will finally provide for that necessary "second opinion" the American public deserves.

---

[33]Freerick, *Twenty-Fifth Amendment*, xxiii.

The Illness and Death of President Franklin D. Roosevelt

Hugh E. Evans and Robert H. Ferrell

Sometimes a significant event requires half a century to become evident in its particulars. The illness and death of President Franklin D. Roosevelt certainly illustrates this phenomenon. For years after his death, uncertainty predominated. Supposedly informed individuals, including the president's personal physician, Surgeon General of the U.S. Navy Ross T. McIntire, offered self-serving interpretations. In his 1946 book, *White House Physician*, Ross McIntire made only passing mention of a lieutenant commander, Dr. Howard G. Bruenn.[1] Bruenn, however, was not an inconsequential figure. He was a graduate of The Johns Hopkins Medical School and a faculty member at Columbia University's School of Medicine in New York City. He had an excellent reputation as a skilled cardiologist. In 1944 he recognized that Ross McIntire was overlooking the president's severe hypertension, thus permitting severe congestive heart failure to develop earlier than necessary.

Bruenn first saw the president on March 28, 1944 and became, in effect, Roosevelt's personal physician. He saw the president almost daily and managed to keep him alive until April 12th of the next year, while McIntire remained the president's official physician. Nonetheless, McIntire did not consult Bruenn before publicizing his account of Roosevelt's illness and only gave Bruenn a copy of his book after it appeared. Bruenn remained silent for a quarter of a century until he published an article about Roosevelt's health in a leading medical journal.[2] Unfortunately, many false interpretations of Roosevelt's condition have survived Bruenn's 1970 publication. Some of these were refuted by the 1995 publication of the diary of Margaret (Daisy) Suckley, the president's cousin and confidante.[3]

---

[1]Ross T. McIntire and George Creel, *White House Physician* (New York: Putnam, 1946).

[2]Howard G. Bruenn, "Clinical Notes on the Illness and Death of President Franklin D. Roosevelt," *Annals of Internal Medicine* 72 (1970), pp. 579–591.

[3]Geoffrey C. Ward, ed., *Closest Companion: The Unknown Story of the Intimate Friendship between Franklin Roosevelt and Margaret Suckley* (Boston: Houghton Mifflin, 1995).

Questions about President Roosevelt's health remain. The effect of his illness on his country, particularly on foreign and domestic issues during the final years of World War II, is of particular importance. There is little doubt that the President retained his mental faculties during those years. As Senator Harry S. Truman said to reporters at the White House gate after lunching with President Roosevelt outdoors on August 18, 1944, he was still the leader he always had been, and no one should "kid them" about it.[4] We know, however, that the president was ill and tired and that this illness might have had some effect on the course of our nation's history. It is these effects that we would like to explore, not to resolve them but rather to urge them upon the attention of historians and physicians.

At least three erroneous diagnoses of President Roosevelt's illness have been presented to the public. It is worthwhile describing them, as they have colored discussions of Roosevelt's illness and death despite the corrective tonic of Bruenn's article in 1970. The "mystery" of Roosevelt's death continues. Verne W. Newton, the present director of the Roosevelt Library, mentioned one of the false diagnoses when the College of Physicians' exhibit on presidential disability appeared on C-Span.

McIntire's perspective remains the most striking, perplexing, and even astonishing misdiagnosis of Roosevelt's illness. McIntire repeated his views throughout the war and even in 1944–45 after the president's illness had become acutely life threatening. He repeated them in his book and then again and again until his death in 1959.

McIntire insisted that the president was basically a well man, or at least as well as could be expected for his age (the president was sixty-three when he died). McIntire attributed FDR's obvious deterioration to the president's chronic bronchitis and not to severe hypertension and the resulting congestive heart failure. On January 29, 1944, McIntire said that the president was "in his best health ever." On March 5th it was "the finest possible health" and "in perfect shape." At Roosevelt's fourth inauguration in January of 1945, less than three months before his death, McIntire claimed that "everything's fine." The president, he said, was carrying a "thunder of a lot of work and getting away with it." He "went through the campaign [of 1944] in fine shape," McIntire claimed.[5] When the

---

[4]*New York Times*, August 19, 1944, as quoted in Margaret Truman, *Harry S. Truman* (New York: Morrow, 1973), p. 185.
[5]*The New York Times*, January 30th, March 6th, 1944, January 21, 1945.

president died of a massive cerebral hemorrhage, McIntire told Secretary of State Edward R. Stettinius, Jr., that "it was something absolutely new and came as a complete surprise. The president's blood pressure was all right and had been for some time, and there was absolutely no apparent cause for the stroke [sic]."[6]

Five years later, on March 5, 1951, James A. Farley, Postmaster General under Roosevelt, published a letter in *The New York Times*. "It was widely known among political leaders," he wrote, "that he [FDR] was a dying man."[7] *The Washington Star* picked up the story the next day by including Farley's words in its leading editorial. McIntire responded with a three-column piece in *The Star* essentially repeating his original remarks.[8] *U.S. News and World Report* entered the fray on March 23 with an article entitled "Did the U.S. Elect a Dying President?"[9]

McIntire had been selected as President Roosevelt's doctor at the recommendation of Woodrow Wilson's personal physician, Rear Admiral Cary T. Grayson. Grayson's own credentials were less than solid. He had received his medical degree after one year of study at a school in Virginia that did not survive the educational reforms associated with Abraham Flexner's well-known *Report* of 1910. One of Grayson's successors as White House physician, Joel T. Boone, visited him on several occasions during the early 1920s while Grayson was still caring for Wilson. Grayson's desk, Boone recalled, was always piled high with unopened medical journals.[10] McIntire, however, had specialized in otolaryngology and was therefore an appropriate choice for a patient with recurrent sinusitis, bronchitis, and upper respiratory tract infections. As a professional naval officer, he was expected to maintain a discreet silence if needed.

It is possible that McIntire's optimistic view of President Roosevelt's health was the result of wartime pressure to deny the president's illness in the interest of national security. Alternatively, Roosevelt, McIntire's commander in chief, may have instructed the doctor not to disclose negative findings. These pressures, however, would not have persisted after the end of the war or the president's death.

---

[6]Thomas M. Campbell and George C. Herring, eds., *The Diaries of Edward R. Stettinius, Jr., 1943–1946* (New York: New Viewpoints, 1975), p. 316.

[7]James Farley, letter to the editor, *The New York Times*, March 5, 1951.

[8]*The Washington Star*, March 10, 1951.

[9]"Did the U.S. Elect a Dying President?: The Inside Facts of the Final Weeks of FDR," *U.S. News and World Report*, 30 (March 23, 1951), pp. 19–22.

[10]Joel T. Boone, unpublished autobiography, Library of Congress.

The role of McIntire's co-author, George Creel, needs to be considered as well. The nature of McIntire's relationship with Creel is not entirely clear, despite the considerable correspondence contained in McIntire's papers at the Roosevelt Library. Creel probably approached McIntire about the book. The awkwardness of writing about the former president's diagnosis and prognosis soon caused difficulties and the correspondence between McIntire and Creel became increasingly acrimonious.[11] McIntire appears to have withdrawn from active involvement in the project and Creel was left to write most of the book on his own. The resulting volume, nonetheless, was published with McIntire's name as first author. Instead of serving as an opportunity to revise or temper his original remarks, the book only made it less likely that McIntire would ever address the issue of President Roosevelt's health in a forthright manner.

The situation has been made even more complicated by the strange disappearance of President Roosevelt's medical records after Commander Bruenn wrote his final notes. Only three physicians should have had access to the records: McIntire, the Officer in Command at Bethesda Naval Hospital, and the Executive Officer of Bethesda Naval Hospital. Bruenn and others have suggested that McIntire could have removed the files and that he had reasons to do so.[12]

McIntire was only one source of erroneous information about Roosevelt's health. Several physicians suggested that Roosevelt died from the cumulative effect of a series of small strokes until this possibility was definitively refuted by Dr. James A. Halsted in his 1962 article, "F.D.R.'s 'Small Strokes': A Medical Myth."[13]

The theory that Roosevelt had stomach cancer or a malignant melanoma has surfaced on several occasions. The cancer theory cannot be disproved but certainly seems unlikely. The possibility of stomach cancer, in particular, first emerged during the Teheran Con-

---

[11]Box 12, McIntire Papers, Franklin D. Roosevelt Library, Hyde Park, New York.

[12]During an interview with Jan Herman, Commander Bruenn suggested that McIntire may have removed Roosevelt's files. Jan Herman, "The President's Cardiologist," *Navy Medicine* vol. 81, no. 2 (March–April, 1990), p. 11. An extensive search of the federal records center in St. Louis where the president's files would have gone has been fruitless. McIntire's files were requested and the center's staff were also instructed to search under the pseudonyms used when the President had medical tests at Bethesda.

[13]Karl C. Wold, *Mr. President—How is Your Health?* (St. Paul, MN: Bruce, 1948); Rudolph Marx, *The Health of the Presidents* (New York: Putnam, 1960); James A. Halsted, "F.D.R.'s 'Small Strokes': A Medical Myth," *Today's Health* 40 (1962), pp. 53, 74–75.

ference in 1943. It was rekindled in April and May of 1944 when the president suffered from two gall-bladder attacks confirmed by x-ray imaging.

Shortly before his death in 1953, Frank H. Lahey, a navy consultant who had seen the president once or maybe twice, wrote a memorandum apparently stating that the president had had stomach cancer. Lahey entrusted this memorandum to Linda M. Strand, who was both the business manager of his clinic and the executor of his estate. Upon receiving the document in 1953, Linda Strand deposited it with her lawyers. She had been instructed to publish it if Lahey was posthumously criticized for his care of President Roosevelt. When, at the age of eighty-nine, Linda Strand requested the memorandum from her lawyers, the firm refused to return it. Initially, Harry S. Goldsmith, a physician on the faculty of Dartmouth Medical School, sued the firm at her behest. He had heard of the memorandum a number of years before during a lecture by George Pack, M.D. The case was originally decided in favor of the law firm. Meanwhile, Linda Strand became more actively involved. She took her suit before the state supreme court and won. She died in 1989, but a year later Dr. Goldsmith telephoned the Lahey Clinic to say that he had a copy of the memorandum and would be publishing it in the near future.[14]

The theory that Roosevelt had a melanoma is equally questionable. This theory originated during a medical meeting in St. Louis in 1949. A team of surgeons from Walter Reed Hospital was speaking about melanomas. Their slides had serial numbers except for one, which showed a melanoma of the brain. This one carried the date April 14, 1945. In 1961 a Kentucky physician, F.M. Massie, published his belief that the slide may have been a specimen from Roosevelt's brain, because April 14, 1945 was the day Roosevelt's body arrived in Washington. Massie was apparently unaware of the fact that there had been no autopsy in Roosevelt's case and that the president's records were at Bethesda, not Walter Reed. Although the authors (Evans and Ferrell) have been unable to locate Massie's article, the British physician Hugh L'Etang perpetuated this diagnosis by citing Massie's article in his 1970 book, *The Pathology of Leadership*.[15]

In 1979 Goldsmith added to the debate by publishing an article which included several photographs of Roosevelt with a pigmented

---

[14]Harry Goldsmith, M.D. has not published the memorandum to date.

[15]Hugh L'Etang, *The Pathology of Leadership* (New York: Hawthorn, 1970), p. 15.

area over his left eye. Serial pictures from the 1930s and 1940s show steady enlargement of this lesion until it disappears in 1944.[16] A few years ago Robert P. Hudson, then President of the American Association for the History of Medicine, delivered a paper based on Goldsmith's article.[17] His findings, however, did not support the melanoma theory. The lesion over Roosevelt's eye appeared in 1944, a year before his death. A malignant melanoma would have progressed much more rapidly. In addition, Dr. Bruenn and others have said that Dr. Winchell M. Craig of the Mayo Clinic excised a sebaceous cyst from the president's face in early 1944. Daisy Suckley's diary also confirms that four physicians, including McIntire, removed a cyst from the back of Roosevelt's head on February of 1944 and that the cyst was non-cancerous. It is plausible that the cyst above the president's eye was removed at the same time.[18]

The true cause of Roosevelt's failing health and untimely death was recognized by Howard Bruenn in March of 1944. On his first examination, Bruenn concluded that the president was in "Godawful" condition from the effects of hypertension and associated cardiac disease as well as bronchitis.[19] Bronchitis and sinusitis were the only conditions McIntire had recognized to date.

A medical board including Frank Lahey and James A. Paullin was convened after Bruenn's examination. Although the consultants initially dismissed Bruenn's request for rest and digitalis, Bruenn stood up to them. He was the only cardiologist in the group and he made it clear that neither rank nor reputation would intimidate him. Lahey and Paullin visited the White House that afternoon and by the next morning permitted Bruenn to initiate his medical plan. The results were dramatic. The president's symptoms of bronchitis diminished, his heart function improved, and he was able to sleep soundly for the first time in months.

When Bruenn reviewed the president's records, he found minimal evidence of the annual head-to-toe examinations that McIntire claimed he had performed. Nor were there many blood pressure readings. A normal reading taken for a life insurance policy had been heavily publicized in 1931 just as Roosevelt entered the race for his first presidential nomination. The sparse readings thereafter should

---

[16]Harry Goldsmith, "Unanswered Mysteries in the Death of Franklin D. Roosevelt," *Surgery, Gynecology, and Obstetrics*, 149 (1979), pp. 899–908.

[17]"The Last Illness of Franklin D. Roosevelt," unpublished address, American Association for the History of Medicine, Rochester, N.Y., 1986.

[18]Suckley diary, February 1, 4, 1944, Ward, ed., *Closest Companion*, pp. 275, 277.

[19]Interview with Howard Bruenn, M.D. by Robert Ferrell, February 16, 1992.

have raised alarm as the systolic and diastolic levels rose too rapidly. The president's pressure was 136/78 in 1935, 162/98 in 1937, 178/88 by 1940, and 188/105 in 1941. Although he did not actually examine the president until 1944, Bruenn believed that Roosevelt should not have run for a third term in office. Dr. Wallace Yater, a prominent internist and physician to Roosevelt's confidant, Harry Hopkins, had met Roosevelt socially. When Hopkins spoke enthusiastically of FDR's running for a third term, Yater remarked that this would "kill him" (FDR).[20] A medical student from the University of Michigan, Carroll Leevy, met FDR during the summer of 1940 as one of several young, distinguished Afro-Americans invited by Mrs. Roosevelt. He was impressed by FDR's firm handshake, wit, and charm, but dismayed at his appearance of severe fatigue.[21]

Instead, the president's illness intensified. In 1944, after having spent several weeks in July and August in Hawaii and Alaska, the president suffered an attack of angina while delivering a speech from the forecastle of a destroyer at Bremerton Naval Base. Because the president was usually carried or pushed in his wheelchair, this was the first episode of angina that Bruenn had observed.[22] At the second Quebec Conference in September 1944, the president's pressure reached 240/130. In December, after a swim in the Warm Springs pool, it was 260/150. There were wide swings in the president's blood pressure. After an argument with his wife Eleanor over the provision of aid to Yugoslavia, FDR's pressure rose an additional fifty points. "That gal [Eleanor] had tunnel vision," Bruenn told an interviewer in 1989.

> We were down at Warm Springs sometime early in 1944 [1945]; I told them [the family] how important it was not to irritate him, not to make things difficult. When we were at Warm Springs, we got a telephone call about 8:30–9:00 down there. I was in the bedroom talking to him. The telephone rang and it was Mrs. Roosevelt. They were always very polite to each other. She had been to a meeting called "Young Yugoslavia," and she had been really greatly moved by the deplorable condition of the partisan group and so forth who were fighting the

---

[20]Luongo, E.P., *A Biography of Wallace MasonYater, M.D.* (Privately published, 1982), p. 101.

[21]Interview, May 1998 with Dr. Leevy, Chairman Emeritus and Professor of Medicine, New Jersey Medical School.

[22]Howard G. Bruenn, "Clinical Notes on the Illness and Death of President Franklin D. Roosevelt," *Annals of Internal Medicine* 72 (1970), p. 586.

> Germans. She insisted that the President send supplies and arms to help them. He explained to her very calmly and clearly that there was no way of getting the stuff in there. "Impossible." She insisted. And for the next several minutes she was after him to do this. He was always polite and said, "I'm sorry, Eleanor, but I can't do it." Just two weeks after I told the family not to get him upset—his blood pressure after this conversation was markedly elevated.[23]

During the last year of President Roosevelt's life, he often confided his difficulties to his cousin Daisy Suckley. He communicated with her by telephone from Hyde Park and Washington and she was in the room at Warm Springs when he collapsed on April 12, 1945. Suckley was very fond of Roosevelt and, unlike his wife, listened to his ailments and troubles. Her description of his fatigue runs like a skein through the entries of her detailed diary. In March of 1945 he called her from Washington one morning, telling her how tired he was and that he wanted to get off to Warm Springs to "sleep & sleep & sleep." The next evening he called again from the blue oval office next to his bedroom and said that he would go to bed after cleaning up a pile of papers sitting on the chair next to his desk. He said he was "suffering from exhaustion," but would leave for Warm Springs on Saturday night.[24]

Did Roosevelt know that the heart failure Bruenn had diagnosed the year before was responsible for his fatigue? He never asked Bruenn to explain what ailed him and never asked about his blood pressure.[25] Bruenn, however, was certain that Roosevelt realized he was a cardiologist. Henry Morgenthau's diary reveals that on the very night before his death, Roosevelt said that he knew a heart specialist at Columbia Presbyterian, presumably Bruenn.[26]

It is also unclear to what extent the president discussed his condition with his daughter Anna. By the Yalta Conference in February of 1945 she certainly knew what was wrong with him. In a letter to her second husband, John Boettiger, she referred to "OM", the old man, her father, and his "ticker trouble." She had been brought up to date by Bruenn, with instructions not to discuss the matter with

---

[23]Howard Bruenn, interview by Brenda Heaster, April 21–22, 1989.
[24]Ward, ed., *Closest Companion*, p. 400.
[25]Howard G. Bruenn, "Clinical Notes on the Illness and Death of President Franklin D. Roosevelt," *Annals of Internal Medicine* 72 (1970), p. 583.
[26]Diary of Henry Morgenthau, April 11, 1945, Franklin D. Roosevelt Library.

McIntire.[27] She told her husband to tear off and destroy that paragraph of her letter. Doris Kearns Goodwin has suggested that Anna had learned about Roosevelt's diagnosis from Bruenn at a much earlier date and had tried to learn more about cardiovascular disease at the time.[28] Anna's appreciation of the severity of her father's illness probably increased substantially at Yalta when Roosevelt developed pulsus alternans. This development showed Bruenn that the president's cardiac reserve was limited. It seems unlikely, however, that Anna discussed these concerns with her father. Years later she told Richard Rovere, who was beginning a book about Truman, that she did not believe that her father had any idea of how ill he was. "No," she said, "I don't think he had the slightest idea that he was going downhill in the way he was."[29]

The question of what Roosevelt knew and accepted is partially addressed by material in Daisy Suckley's diary. According to Suckley, George Fox, the president's physical therapist, frequently took the president's blood pressure, probably unbeknownst to Bruenn. On January 12, 1945 Daisy wrote, "Fox takes the blood pressure. It has been good . . . & today was a record 'low': 190/88. F [Franklin] thinks I am wrong about the 88, that that it was 98 . . ."[30] On April 10th she wrote, "Dinner was nice again, and the Dr. came about 9:20 and F. very soon went off to his room. The blood pressures were below the 100–200 marks and we hope will stay there."[31]

Daisy wrote openly about the president's heart trouble. On May 5, 1944 she noted that

> From a later talk with the P. the trouble is evidently with the heart—the diastole and systole are not working properly in

---

[27]Anna to John Boettiger, February 7, 1945, Robert Ferrell, *Ill-Advised: Presidential Health and Public Trust* (Columbia: University of Missouri Press, 1992), p. 47.

[28]Doris Kearns Goodwin, *No Ordinary Time: Franklin and Eleanor Roosevelt, The Home Front in World War II* (New York: Simon and Schuster, 1994), p. 579.

[29]Anna Roosevelt Halsted made a similar remark to Howard Bruenn in 1969: ". . . you say in your manuscript that it was suggested by the consultant group in March 1944 that the President be informed of the seriousness of his health situation: Do you know if he was actually so informed and, if so, what was his response, if any? Did he ask questions, especially those which would relate to prognosis? It occurs to me that McIntire might have informed the group that he would undertake to inform the President, and that as McIntire was both White House Physician as well as Surgeon General, no one queried him as to whether or not he had informed the President and, if he had, what was the President's reaction." Anna Roosevelt Halsted to Bruenn, October 24, 1969, box 8, Anna Roosevelt Halsted Papers, Franklin D. Roosevelt Library.

[30]Ward, ed., *Closest Companion*, p. 380.

[31]Ibid., p. 414.

> unison . . . I had a good talk with the P. about himself—He said he discovered that the doctors had not agreed together about what to tell him, so that he found out that they were not telling *him* the *whole* truth and that he was evidently more sick than they said! It is foolish of them to attempt to put anything over on *him*![32]

On December 15 she wrote, "I am *hoping* to get a little closer to the doctors, so that they will talk more freely to me . . . They seem to be concentrating on the Pres.' heart. He himself said it was a 'cardiac' condition . . ."[33]

What Roosevelt drew from the blood pressure readings provided by Fox is difficult to know. He was an extraordinarily secretive man. Henry A. Wallace preserved a remark of Anna Roosevelt, to the effect that "He doesn't know any man and no man knows him. Even his own family doesn't know anything about him."[34] Roosevelt did tell Daisy that he could resign a year into his fourth term, when the war was over. He could return to Hyde Park, keeping his hand in affairs, as he was sure he would be consulted.

Having acknowledged the significant extent of Roosevelt's illness during his final term, we must ask what effect his health problems had on the nation. Until the Teheran Conference during the winter of 1943, the president's physical condition was fairly good. We do have evidence, however, that during the final year of his presidency his health was poor. He was often tired. Although his private secretary, Grace G. Tully, observed a few lapses, she did not think that he was ever "out of it" or unable to understand what was going on. His concentration had deteriorated. Failing health compelled him to take numerous vacations, including almost a full month in South Carolina. His restorative trips to Hyde Park were too numerous for a man with his responsibilities. Never an enthusiastic administrator, he let even more things slip during his final illness. An official in charge of White House files during most of Truman's administration once said,

> Mr. Roosevelt would go away on a trip and he'd come back, and he'd be busy with something else, and then he'd go away again and come back, and I have had papers waiting for Pres-

---

[32]Ibid., p. 296.
[33]Ibid., p. 363.
[34]John Morton Blum, ed., *The Diary of Henry A. Wallace, 1942–1946* (Boston: Houghton Mifflin, 1973), p. 380.

> ident Roosevelt's signature piled on the table behind his desk for six months. They'd stand there for six months waiting for his signature. Even, for example, pardons or paroles, and an individual who was waiting for his pardon spent six months longer waiting in the penitentiary than he would have if the President had signed.[35]

The clearest effect of FDR's malignant hypertension and congestive heart failure was a marked reduction in the number of hours worked each day. Indeed this was the cornerstone of Dr. Bruenn's prescription. Could FDR, or any other president, fully meet his responsibilities with only two hours of work in the morning and the same in the afternoon? Dr. Bruenn felt that this was the "ideal" regimen for conserving the president's waning strength and prolonging his life.

Two important issues dominated the last year of Roosevelt's presidency: the selection of a vice president and strategy toward Japan. The material concerning the former issue is fascinating in its detail, for behind the president's seemingly casual choice of Senator Truman for the vice-presidency was nothing less than a coup organized by the party leaders, who had observed FDR's declining health, were uncertain of its cause, but felt very strongly that Vice President Wallace could not possibly take Roosevelt's place in the event of the president's death. Wallace was not a veteran politician, and indeed had not run for public office until nominated for the vice-presidency in 1940. The party leaders opted for Truman, whom they knew well, and carefully—without explaining their reasoning—talked Roosevelt out of Wallace and into Truman. In the course of their maneuvering it became evident that both Wallace and Roosevelt's "assistant president," former senator and associate justice of the Supreme Court James F. Byrnes, desired the nomination, for the obvious reason that it implied a presidential appointment. There was a great deal of confusion at the party's convention in Chicago until the important issue of Truman's nomination was straightened out.[36]

Neither FDR nor Bruenn apparently considered Truman a successor, at least not in the immediate future.[37] FDR's failure to consult

---

[35]William Hopkins as quoted in Ferrell, *Harry S. Truman: A Life* (Columbia: University of Missouri Press, 1994), p. 181.

[36]For a more detailed account of Truman's 1944 nomination, see Robert Ferrell, *Choosing Truman* (Columbia: University of Missouri, 1994).

[37]Interview with Howard Bruenn, M.D. April 17, 1993, October 21, 1993, September 21, 1994.

with his new vice-presidential nominee in 1944 was consistent with the marginal role that vice-presidents played at the time. FDR does not appear to have anticipated his death. Similarily, comments Truman made to Secretary of State Stetinius on April 12th and to the Budget Director, Harold Smith, a week later reveal that, on some level at least, the new president was quite surprised.[38]

With respect to the war with Japan, the ill and enervated president soon found himself in the middle of a closely drawn battle between Admiral Chester W. Nimitz and General Douglas MacArthur over whether to defeat the Japanese through an island-hopping approach via the Philippines or through a direct assault on the Japanese home islands. After an extensive debate, Roosevelt decided in MacArthur's favor on the basis of instinct and, one might suspect, out of fatigue. His decision may have prolonged the war in the Pacific. It allowed the entry of Soviet forces into the Pacific war and helped create the conditions that led to the detonation of the first atomic weapons. There were, however, equally compelling military and political reasons in favor of Roosevelt's decision.

The sickness and death of the president during a major war was exceedingly important. Fortunately Roosevelt was able to hand over power to a man with enough intelligence and political understanding to carry the nation forward to victory and then to guide it through the extraordinarily difficult years that lay ahead.

---

[38]Papers of Harold Smith, Director of the Budget, Franklin D. Roosevelt Library, Hyde Park, New York.

Visitor Survey

By August of 1998 over 6,500 visitors to the exhibition "When the President is the Patient" had participated in a poll on presidential health issues. Although the 6,500 voters represent only a fraction of all visitors to the exhibition, their choices indicate a majority commitment to privacy and autonomy in medicine. The results of the survey are summarized below.

1. Should the president have control over information that is released about his or her health? 75% YES 25% NO
2. Should the president choose his or her own physician? 87% YES 13% NO
3. Should the military "assign" physicians to the White House? 22% YES 78% NO
4. Should Congress approve the president's choice of the White House physician? 31% YES 69% NO
5. Should all of the results of the president's annual check-up be made public? 29% YES 71% NO
6. Should an independent commission examine the president annually and make its findings public? 26% YES 74% NO

Portrait of Benjamin Rush, M.D. (1745–1813)
Collection of the Library of the College of Physicians of Philadelphia

Inoculation, Patients, and Physicians: The Transformation of Medical Practice in Philadelphia, 1730–1810

Sarah Blank Dine

As Benjamin Rush (1745–1813) neared the end of his long and active life, he wrote an essay comparing the state of medicine in Philadelphia between 1760 and 1766 and the first decade of the nineteenth century. Rush's essay appeared in his multi-volume work *Medical Inquiries and Observations,* which he revised several times before his death in 1813. His own career fits neatly in the parameters of his comparative dates. Rush started his medical studies in 1760, opened his own practice in 1769, and had perhaps Philadelphia's largest medical practice during the end of the eighteenth century. Rush's practice in the nineteenth century was still a busy one, if not quite as voluminous as in earlier years.[1]

One of the changes Rush noted in his essay was "the almost universal extirpation of the smallpox," which he credited to the adoption of the Jenner's vaccine as promoted by Dr. John Redman Coxe and John Vaughan. While Rush acknowledged the effort of his teacher, John Redman, at promoting the earlier technique of inoculation, he stated it was not universally accepted.[2] Another positive change Rush saw was in childbirth. According to Rush in 1760, few physicians were employed [routinely] as man-midwives, but in 1809 there were distinguished male physicians employed in midwifery, physicians of regular and extensive educations, and through their acceptance by the citizens of Philadelphia, death from pregnancy

---

[1]Benjamin Rush's patient accounts are part of the Rush Collection owned by the Library Company of Philadelphia on deposit at the Historical Society of Pennsylvania. They include nine account books, called journals, that run from 1769 to 1813, five day books from 1772–1796 and five rough ledgers. The estimates of patient volumes comes from the nine journals. Hereafter cited as Rush, Journal #, PPL.

[2]Benjamin Rush, "An Inquiry into the Comparative State of Medicine in Philadelphia between 1760 and 1766 and 1809," in Benjamin Rush, *Medical Inquiries and Observations*, 4 vols. in 2, 4th edition (Philadelphia: Griggs & Dickinson for M. Carey, 1815), vol. 4, pp. 225–49.

and parturition were rare occurrences. He also acknowledged advances in understanding the anatomy of reproduction by William Potts Dewees.[3]

One of the causes for these advances, Rush thought, was the "diffusion of medical knowledge among all classes of citizens, by means of medical publications and controversies." Rush credited printed sources, which would immediately bring to mind such works as Buchan's *Domestic Medicine*, reprints from *Gentleman's Magazine* in American newspapers, various Philadelphia medical and scientific journals, and Noah Webster's *A Brief History of Epidemic and Pestilential Diseases*, as well as the newspaper controversies over Rush's role in the yellow fever epidemics, with "allowing the populace to know so many of the principles of medicine that they are able to prescribe for themselves to prevent illness from becoming fatal." In a statement that would warm the hearts of many a pediatrician and general practitioner, he noted that by learning so much the general population had less need to rouse a doctor in the middle of the night to treat emergencies.[4]

The adoption of inoculation and later vaccination for smallpox, the shift from female midwife to male obstetrician, and the broad cultural, social, and economic changes that created a class of lay readers and a market for medical advice books have been discussed by historians in many articles and books.[5] I would like to look at these

---

[3]Ibid., pp. 232, 242.

[4]Ibid., p. 247; Charles E. Rosenberg, "Medical Text and Social Context: Explaining William Buchan's Domestic Medicine," *Bulletin of the History of Medicine 57* (1983), pp. 22–42; C.J. Lawrence, "William Buchan; Medicine Laid Open," *Medical History 19* (1975): 20–33; Roy Porter, "Laymen, Doctors and Medical Knowledge in the Eighteenth Century: The Evidence of the *Gentleman's Magazine*," in Roy Porter, ed., *Patients and Practitioners, Lay Perceptions of Medicine in Pre-Industrial Society* (Cambridge: Cambridge University Press, 1987), pp. 283–314; Mark A. Smith "Andrew Brown's 'Earnest Endeavor': The Federal Gazette's Role in Philadelphia's Yellow Fever Epidemic of 1793," *Pennsylvania Magazine of History and Biography* 120 (1996), pp. 321–43; Martin Pernick, "Epidemic Yellow Fever in Philadelphia and the Rise of the First Party System," *William & Mary Quarterly,* Third Series 29 (1972), pp. 559–86; more generally, the first chapter of Lamar Riley Murphy, *Enter the Physician: The Transformation of Domestic Medicine 1760–1860* (Tuscaloosa: University of Alabama Press, 1991).

[5]Adrian Wilson, *The Making of Man-Midwifery Childbirth in England, 1660–1760* (Cambridge: Harvard University Press, 1995); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986); Murphy, *Enter the Physician;* J.H. Plumb, "The New World of Children in Eighteenth Century England," *Past & Present* 67 (1975), pp. 64–96; Cathy Davison, *Revolution and the Word: the Rise of the Novel in America* (New York: Oxford University Press, 1986), chapter 2; William T. Gilmore, *Reading Becomes a Necessity of Life: Material and Cultural Life in Rural New England 1780–1835* (Knoxville: Uni-

three factors in unison in order to examine the ways in which these transformations affected the practice of medicine between regular physicians and their patients in Philadelphia at the close of the eighteenth century and the beginning of the nineteenth century.

Smallpox had been the leading cause of death from infectious disease in Philadelphia before 1760. Endemic in Europe for many centuries, smallpox became a fatal epidemic disease during the seventeenth century, killing many young children who lacked immunity to the disease. It proved particularly fatal in certain Quaker communities in England.[6] While no one then understood the germ theory, a literate elite broadly understood the concept of immunity. Boston's ministers, for instance, became very concerned when smallpox reappeared in 1721. The last outbreak of smallpox had been in 1702, and the passage of nineteen years created a whole new class of susceptible persons. Benjamin Colman, a Boston Congregational minister, wrote in 1719: "The small Pocks has from the beginning of the Country been very mortal here, and now it is sixteen years since it has spread among us, so that all our Children from those years and under age to have it, besides a great number of adult people. Should it stay away as many years more and then come it would double our distress." It is not surprising that Colman was a strong supporter of Zabdiel Boylston, the Boston physician who started inoculation. Boylston was also a congregant of Colman's at the Brattle Street Church.[7]

Controversy over smallpox inoculation in the American colonies began in Boston during the outbreak in 1721. A similar controversy erupted when smallpox struck Philadelphia in 1731.[8] One of the

---

versity of Tennessee Press, 1989); Roy Porter, "The Rise of Medical Journalism in Britain to 1800," in W.F. Bynum, Stephen Lock, and Roy Porter, eds., *Medical Journals and Medical Knowledge Historical Essays* (Routledge: London, 1992), pp. 6–29; Dorothy Porter and Roy Porter, *Patients' Progress. Doctors and Doctoring in Eighteenth-Century England* (Stanford: Stanford University Press, 1989).

[6]Peter Razzell, *The Conquest of Smallpox: The Impact of Inoculation on Smallpox Mortality in Eighteenth-Century Britain* (Firle: Caliban Books, 1977); Chris Galley, "A Never Ending Succession of Epidemics? Mortality in Early Modern York," *Social History of Medicine* 7 (1994), pp. 29–52; Roslyn Stone Wolman, "Some Aspects of Community Health in Colonial Philadelphia." (Ph.D. diss., University of Pennsylvania, 1974), chapter 3.

[7]Benjamin Colman to Robert Woodrow, January 23, 1719, in Niel Caplan, "Some Unpublished Letters of Benjamin Colman 1717–1725," *Proceedings of the Massachusetts Historical Society, Fourth Series*, 77 (1965), p. 113.

[8]John B. Blake, *Public Health in the Town of Boston 1630–1822* (Cambridge: Harvard University Press, 1959), chapter 2; Worthington C. Ford, "Franklin's New England Courant," *Proceedings of the Massachusetts Historical Society, Fourth Series*, 57 (1923–24), pp. 336–53.

leading opponents of inoculation had been James Franklin, Benjamin Franklin's older brother and owner of the *New England Courant*. In 1731, Benjamin Franklin was living in Philadelphia and had become an ardent supporter of inoculation. He wrote his sister that fifty persons had been inoculated and only one died. Smallpox again struck Philadelphia in 1736 and Franklin's son died of the disease. Franklin angrily denied that Francis Folger Franklin had died of inoculation, but rather had been too sickly to be inoculated and had died after catching the disease naturally. Franklin had his daughter, Sarah, inoculated in April, 1746, when she was two and a half.[9] Philadelphians also began to understand that smallpox acquired through inoculation was safer than getting it the natural way. Margaret Fraeme wrote to her brother John Penn in October, 1736: "[I] find Bro: Tom sent you word of out att last consenting to have him [Thomas Fraeme, Jr.] inoculated. The small-pox has and doth rage Very much in this City, Numbers of Persons Dying of it, at last seeing it Prove so fatal in the Common way, that by a computation one dy'd in four, and not one in fifty by inoculation, Mr. Till concluded to have his wife and his 2 children, Mr. Taylor his little Boy, and dievers other that has succeeded very well."[10]

Smallpox had been epidemic twice in the 1730s, first in 1731, and again in 1736. It returned to Philadelphia in 1746 when Franklin had his daughter inoculated. Despite the fact that Philadelphia's physicians of the period, the brothers Thomas and Phineas Bond, John Kearsely, Lloyd Zachary, William Shippen Sr., Thomas Cadwalader, and others supported inoculation and were among the first to have themselves inoculated in 1731, inoculation was not widely practiced in Philadelphia during the first two decades of its use.[11] Neither John Kearsley's account book at the National Library of Medicine, which only goes up to 1731, with some entries through 1736, nor the ledgers of Thomas and Phineas Bond, which start in 1754, reveal any inoculations before 1756. Possibly one of the reasons was that, during the November 1750 outbreak, it was reported

---

[9]Benjamin Franklin, *The Papers of Benjamin Franklin*, ed. by Leonard W. Labaree, et al. (New Haven: Yale University Press, 1959), vol. 1, pp. 186–87, 200–201, 214; vol. 2, pp. 154; vol. 3, pp. 74, 77–79.

[10]Howard Jenkins, "The Family of William Penn," *Pennsylvania Magazine of History and Biography*, 22 (1898), p. 339.

[11]Wolman, "Community Health," p. 72; William S. Middleton, "The John Kearsleys," *Annals of Medical History* 3 (1921), p. 395; John E. Kieffer, "Lloyd Zachary, 1701–1756, Physician Health Officer," *Pennsylvania Health,* vol. 1, New Series (1940), pp. 25–27.

that three inoculated subjects had died and that doctors were inoculating people in order to gain "extra employment."[12] By 1760, however, the situation had changed dramatically.

Epidemic smallpox again broke out in Philadelphia in June, 1756. Between 1756 and the start of the Revolutionary War, there were five major outbreaks of epidemic smallpox. Very possibly, the continued movements of troops related to the Seven Years War, and Philadelphia's rapid growth in this period, when its population more than doubled from 16,000 to almost 34,000, created a host environment for the virus to flourish amidst persons not previously exposed to the virus and who thus lacked immunity to the disease. Beginning in the 1760s, however, Philadelphia's crude death rate began to drop even with the frequent visits of smallpox. It dropped because of declines in infant and childhood mortality. One of the main reasons for the decline was the adoption of inoculation.[13]

Both Thomas Bond and Benjamin Rush, in retrospective accounts published at the end of the eighteenth century, credited events in 1759 with bringing about a change in public opinion about inoculation. Bond claimed that the techniques he and his brother Phineas learned from a Dr. Barnet who ran an inoculation hospital in Philadelphia in 1759 brought about the change, while Rush claimed the article his mentor, John Redman, wrote supporting inoculations helped persuade the public.[14] While Philadelphia physicians continued to argue about the best preparatory technique for inoculation, it is clear from the Bond ledgers that patients began seeking inoculation in 1756, even prior to the events of 1759 and continued to do

---

[12]Wolman, "Community Health," p. 83; quoting from Samuel Pemberton to his brother September 28, 1750, in the Pemberton Papers, vol. 6, p. 104 in PHi; Benjamin Franklin to Samuel Johnson, September 13, 1750 and October 25, 1750 and Benjamin Franklin to Jane Mecom, September 20, 1750, in Franklin, *Franklin Papers,* vol. 4, pp. 63, 64, 71.

[13]Billy G. Smith, *The "Lower Sort": Philadelphia's Laboring People, 1750–1800* (Ithaca: Cornell University Press, 1990), appendix A; Susan E. Klepp, "Demography in Early Philadelphia, 1690–1860," *Proceedings of the American Philosophical Society,* 133, no. 2 (1989), pp. 96–99; Klepp, "Fragmented Knowledge: Questions in Regional Demographic History," in *Proceedings of the American Philosophical Society* 133, no. 2 (1989), p. 230.

[14]Thomas Bond, *Defense del'Inoculation et Relation* . . . Strasbourg, 1784, quoted in Wolman, "Community Health," pp. 118–21; Rush, "Comparative State," p. 232; Whitfield J. Bell, Jr., "John Redman, Medical Preceptor 1722–1808," in Whitfield J. Bell, Jr., *The Colonial Physician & Other Essays* (New York: Science History Publications, 1975); Whitfield J. Bell, Jr., Letter on Inoculation, 1760 by John Redman, *Transactions of the College of Physicians,* 4th Series, 25 (1957–58), pp. 112–15.

so throughout the eighteenth century, regardless of the presence of the disease.

Phineas Bond began inoculations in May, 1756. Between 1756 and 1772 when the ledgers end, the Bonds performed over 160 inoculations at the request of 105 of their clients. At first the Bonds' patients who requested inoculation for their children, servants and slaves were wealthy merchants, members of the elite, such as Tench Francis, Benjamin Chew, and members of the Mifflin family. Over time, however, their patients included John Howard, a joiner; Samuel Taylor and William Woodhouse, both bookbinders; two barbers; a sailmaker; bakers; and a sugar refiner. Most accounts of inoculation in Philadelphia state that doctors charged £3 per inoculation.[15] While this was the standard charge for the Bonds, looking at their accounts and those of Benjamin Rush, William Shippen, Jr., John Morgan and Benjamin Say, it seems that Philadelphia's doctors had at least a three-tiered system of fees. The Bonds charged their wealthiest patients one fee, their middling patients close to or the standard £3, and then they had another charge for their poorer patients. The Bonds charged their wealthiest clients £4.1 shilling, most of the rest £3, and fees varying from £1.7 to £2.14 for others like John Winter, a carter.[16] Nor were the Bonds the only physicians to offer inoculations during the 1760s. Many other physicians practiced the procedure and many patients sought it out.

In September, 1759, when Elizabeth Sandwith was twenty-four, she recorded in her diary the many visits she paid to friends. Among the people she visited were Henry Steel, who had his son James inoculated for smallpox; Samuel Wharton, whose children were also

---

[15]The Co-Partnership Ledgers of Phineas and Thomas Bond, 6 volumes, owned by the College of Physicians of Philadelphia, hereafter cited as Bond, Ledger # CPP. The six volumes are actually four ledgers or account books and two daybooks. Four of the volumes seem to be exclusively the practice of Phineas Bond; volume 6, a daybook, seems to be the practice of Thomas Bond; and volume 1, which is a ledger, might be a joint ledger or one of Phineas Bond's account books. See also George W. Norris, *The Early History of Medicine in Philadelphia* (Philadelphia, 1886), p. 112; Wolman, "Community Health," p. 121. Many contemporary historians use the £3 figure following Norris's and Wolman's accounts in her dissertation and in Roslyn Stone Wolman, "A Tale of Two Cities: Inoculation Against Smallpox in Philadelphia and Boston," *Transactions of the College of Physicians*, 4th Series, 45 (1977–78), p. 342. Wolman based her figures on the Bond ledgers. See also Smith, *The "Lower Sort,"* p. 107.

[16]Phineas Bond charged Winter £2 per child to inoculate two children. See Bond, Ledger 5, p. 472; CPP; Occupations from Hannah Benner Roach, "Taxables in the City of Philadelphia, 1756," and "Taxables in Chestnut, Walnut and Lower Delaware Wards, Philadelphia, 1767," *Pennsylvania Genealogical Magazine* 22 (1961), pp. 2–41, 170–185.

inoculated; and Thomas Say, whose daughter Rebecca lay ill with smallpox she had caught the natural way. Sandwith noted that in contrast to those inoculated, "smallpox proves mortal to those who take it naturally." Sandwith must have been more than casually interested in the procedure, for in April, 1760, she visited Joseph Howell and was present for the inoculation of two of his daughters, performed by Cadwalader Evans and John Redman. Smallpox was again on her mind at the end of 1762 when her diary entries for December consisted of newspaper stories and accounts of those who died from smallpox. She included lists of those who caught it naturally and died and deaths caused by a mistake by an apothecary in the medication used to prepare the body for inoculation.[17]

The observations Sandwich made before her marriage to Henry Drinker in January, 1761, led her to seek inoculation for all her children. Her first child Sarah was born in October, 1761, and Drinker had her inoculated by John Redman in February, 1762. All her surviving children were also inoculated by Redman or Redman and Cadwalader Evans.[18]

Drinker's choice of Redman is also instructive. She must have been impressed by his technique when she observed it at Joseph Howell's. Redman remained a lifelong friend, paying social calls on the family and visiting with Drinker on their mutual birthdays. Redman, of course, was noted for his courtly ways and the particular attention paid by him to his female patients.[19] In choosing Redman, Drinker turned away from the physicians her mother used, Phineas Bond and William Chancellor, and the physician used by Henry Drinker's relatives and business partners, Thomas Bond. It seems possible that Henry Drinker still preferred Thomas Bond, as Thomas Bond's daybook notes visits to the Drinker children in the 1760s, but they are not noted in the diary.[20] Drinker's ability to choose among physicians also illustrates the enrichment of Philadelphia's medical community in the 1760s. Redman's students (notably Benjamin Rush and John Morgan) began their practices during that decade, as did William Shippen Jr. (not a Redman student), and the medical school of the University of Pennsylvania was founded.

---

[17]Elizabeth Drinker, *The Diary of Elizabeth Drinker*, ed. by Elaine Forman Crane, 3 vols. (Northwestern University Press, 1991), vol. 1: pp. 32, 33, 36.
[18]Ibid., vol. 1: pp. 99, 107, 125, 147, 188, 345–46.
[19]Ibid., vol. 3, p. 1818; Bell, "Redman, Medical Preceptor," p. 22.
[20]Bond ledger 1: p. 55, vol. 6, unpaged, December 7, 1763; July 17, 19, August 2, 7, 1767.

Rush was the youngest of the three, but since his ledgers start with the beginning of his practice, we can also get a glimpse of what inoculation meant to a young doctor. Rush in his *Comparative View* downplayed both the role inoculation played in eradicating smallpox in Philadelphia, and his own role in that process. However, he was much more successful as an inoculator than vaccinator, as many of his attempts at vaccination failed. Over his career, Rush inoculated thousands of Philadelphians and it was an integral part of his practice.[21]

Rush opened his practice in August, 1769. The remaining months of 1769 were slow, for he only saw 40 patients, but by April, 1770, he was averaging 35 patients a month. Rush's practice was already quite busy in 1773, when epidemic smallpox again broke out in Philadelphia. Between January and June of 1773, Rush inoculated 132 people. Inoculations made up half his billing fees in April, 1773.[22] He noted in his autobiographical essay of 1800, *Travels Through My Life*, that he "introduced the Suttonian method of inoculation (popular in England) to America and the method was very popular, bringing him many patients, some of whom continued to employ me in other diseases."[23] For Rush, inoculation and kindness and attentiveness to the poor were cornerstones of building a medical practice. As one of Rush's biographers noted, Rush, like his friend John Fothergill in London, "crept over the backs of the poor into the pockets of the rich."[24]

Rush, like the Bonds, also had a roughly tripartite system of fees for inoculation when he started practicing. His wealthiest patients were charged £3, most of his patients were charged £2 to £2.4 shillings, and his poorest patients were charged £1 to £1.14 shillings. As Rush was first starting his practice, it was not unexpected that his fees were lower than those of the Bonds. The evidence from William Shippen Jr.'s loose accounts and document book in the 1780s indicates that while £3 was the desired price for inoculation, inoculation was widely available at a price less than £3. All of the practitioners charged less for servants and slaves, and Rush, Mor-

---

[21]Rush, Journal Book 8, PPL.
[22]Rush, Journal Book 1, PPL.
[23]Benjamin Rush, *The Autobiography of Benjamin Rush*, ed. George W. Corner (Princeton: Princeton University Press, 1949), pp. 79–80.
[24]David Freeman Hawke, *Benjamin Rush, Revolutionary Gadfly* (Indianapolis: Bobbs Merrill), pp. 82–83.

gan, and Shippen all charged their patients who were members of the Continental Congress or their families more than the going rate, and in some cases substantially more. Consequently, Shippen charged £6 to inoculate Dorothea Quincy, John Hancock's fiancée in June, 1776.[25] John Morgan charged Peyton Skipwith of Virginia £3.10 shillings to inoculate his daughter in 1781.[26] Benjamin Rush charged Josiah Bartlett, a fellow physician and a delegate from New Hampshire, £5.8 shillings for inoculation and Bartlett, in turn, charged the State of New Hampshire £4.12 shillings for inoculation in the expense account he submitted in 1775.[27]

While it is easy to look at the rate that Shippen and Rush particularly charged their better-known patients and view it as exploitation, it is important to recall that this was a hallmark of practice in the eighteenth century, reflecting social attitudes based more strongly on notions of class and deference. Rush instructed medical students in 1789 to "charge the same services higher, to the master or mistress of a family, or to an only son or daughter, who call forth all your feelings and industry, than to less important members of a family and of society . . . As this mode of charging is strictly agreeable to reason and equity it seldom fails of according with reason and sense of equity of our patients."[28] Rush and the other physicians expected their wealthier patients to request more care, attention and medical preparations than middle- and lower-class clients for inoculation and other procedures. In a certain sense, the system worked for eighteenth-century Philadelphians. The small shopkeepers and tradespeople knew that they could pay £2 to £3. Wealthy Philadelphians knew that they could afford not only to have their children inoculated but their servants, slaves, and apprentices as well since they were generally charged less for them. Poorer

---

[25]William Shippen Document Book, p. 25, in the Shippen Family Papers, DLC. Hereafter, Shippen, Document Book or Shippen, Account Book, DLC.

[26]John Morgan Account Book, Journal c. PHi, p. 15. Hereafter Morgan, Journal, PHi.

[27]Rush Journal, Book 2, p. 124, PPL; Frank C. Meyers, ed., *The Papers of Josiah Bartlett* (Hanover: University Press of New England, for the New Hampshire Historical Society), pp. 18–20, 54.

[28]Benjamin Rush, "*Observations on the Duties of a Physician and the Method of Improving Medicine.*" Lecture, University of Pennsylvania, February 1789, printed in Rush, *Medical Inquiries and Observations*, 4th ed., 1: 259–260. See also Gunter B. Risse and John Harley, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5 (1992), pp. 197–98.

Philadelphians, particularly those who had any connection to a regular physician, could also obtain medical services and inoculation for a price as low as £1 without resorting to institutions like the Society for Inoculating the Poor, the dispensary or the alms house.

The wide availability of smallpox inoculation at a price less than the standard quoted price of £3 challenges some assumptions made by historians about Philadelphia's poorer residents and their access to medical care. From the time Benjamin Rush started his medical practice in 1769 until the outbreak of the Revolutionary War, he inoculated approximately two hundred persons. In only nineteen instances during these pre-Revolutionary years did he charge a price of £3 per inoculation. Several patients were charged £3 for two or more inoculations.[29] Billy Smith, in his work on Philadelphia's laboring poor, assumed that at £3 per inoculation, a poor mariner, laborer, cordwainer, or tailor could not afford inoculation. The price would be beyond the means of the workers, the poorest of whom averaged earnings of slightly over £4 a month. Nor could workers afford to lose a week or two of work due to quarantine after inoculation, a time when the inoculee was contagious.[30] The doctors' ledgers tell a different story. Few artisans in the Bond, Rush, Shippen, or Say records were charged a full £3. Most persons sought inoculation for their children, not themselves, and thus would not be kept from work or domestic responsibilities. While most doctors preferred cash and were paid in cash, few received full payment within a short time and all accepted payment in goods and services from tailors, barbers, carters, painters, shoemakers, and others. Some, like Samuel Mitchell, a carter who was a patient of Benjamin Say's, paid his bill in gravel. Others, like Asa Elkington, a tailor, paid his bill partly in cash and partly in clothes. Asa Elkington, likewise a patient of Say's, may have known Dr. Say through their membership in Philadelphia's Northern District Quaker Meeting.[31]

---

[29]Rush, Journal Book 1, PPL.

[30]Smith, *The "Lower Sort,"* pp. 49–50, 107–25. Smith also assumed that inoculation had to be repeated every four or five years, although neither his stated source nor any other I have seen indicated that this was the case. Smith relied on George Norris's *The Early History of Medicine in Philadelphia* (p. 112) for his discussion of the price of inoculation. See above n. 15.

[31]Membership Records of the Society of Friends Northern District Meeting, *Collections of the Genealogical Society of Pennsylvania*, vol. 402, pp. 6, 109, 196. William Wade Hinshaw, *Encyclopedia of American Quaker Genealogy*, 7 vols. (Ann Arbor: Edwin Brothers, 1936–65), vol. 2, p. 644.

The Elkingtons are important in that Billy G. Smith included them in his study of Philadelphia's working poor, *The Lower Sort*.[32] Perhaps the Elkingtons were not typical because they were Quakers, but hundreds of their neighbors in the poorer northern suburbs of Philadelphia can be found in the accounts of Rush, Benjamin Say, and John Syng Dorsey. John Morgan noted in Isaac Andrew's account that he was not to be charged the £2.5 shillings for his son Charles' inoculation, because he was poor. Captain Cresswell's account with Dorsey began in 1805 with the vaccination of a child for $5. The bill due in 1810 for $106 was brought to the attention of Cresswell's widow. Physicians charged their poorer patients less, often times let them carry the bill longer and, depending on the physician and his relationship with the patient and family, sometimes forgave the debt. While it seems that even in the 1720s physicians were generally paid in cash, they all took a certain amount of payment in kind. They also traded services, such as educating their children or stabling their horses, in exchange for medical services rendered.[33]

Leo O'Hara has charged that regular physicians confined their practice almost exclusively to middle- and upper-middle-class families, but their account books tell another story.[34] No Philadelphia physician could afford to limit his practice in such a way—even John Kearsley's account book in the 1720s shows that families from all walks of life used his services. Even a physician like William Shippen, Jr., whom Rush characterized as indolent and mainly interested in keeping convivial company and whom twentieth-century writers have characterized as vain or interested in pleasurable pursuits, had shoemakers, tailors, carters, and carpenters among his patients, particularly during the financially troubled 1780s. While Rush, at the beginning of his practice, bemoaned the fact that he had no great man or patron on whom to rely in starting his practice, few American physicians did.[35] Unlike their English counterparts, American

---

[32]Ledger Book of Benjamin Say, CPP 1796–1804 (alphabetical order); Smith, *The "Lower Sort,"* pp. 14–15.

[33]Morgan, Journal, p. 5, PHi; Ledger Book of John Syng Dorsey, 1804–1808, pp. 19, 132; CPP, Account Book of Benjamin Say, account with S.P. Jones, CPP; Shippen, Document Book, account with James Thompson, p. 110, DLC .

[34]Leo J. O'Hara, *An Emerging Profession. Philadelphia Doctors 1860—1900* (New York: Garland Publishing, Inc., 1989), pp. 16–30.

[35]Rush, *Autobiography*, pp. 322–23; J.H. Powell, *Bring Out Your Dead, the Great Plague of Yellow Fever in Philadelphia in 1793* (Philadelphia: University of Pennsylvania Press, 1949), pp. 31, 36.

Portrait of William Shippen, M.D. (1736–1808)
Collection of the Library of the College of Physicians of Philadelphia

practice was generally inclusive rather than exclusive.[36] Because early nineteenth-century Americans did not differentiate between apothecaries, physicians, and surgeons, Philadelphia's physicians were active in all three spheres until market forces and specialization divided

[36]Rush, *Autobiography*, pp. 78–79. N.D. Jewson, "Medical Knowledge and the Patronage System in 18th Century England," *Sociology* 8 (1975): 369–83.

them again. Few British country physicians practiced inoculation; instead it was left to surgeons or apothecaries. But in Philadelphia physicians practiced inoculation widely, embracing almost the whole social spectrum regardless of a patient's wealth. In the spring months, inoculation could account for a third or even a half of their fees. Account books indicate that inoculation accounted for between 10 and 20 percent of a physician's practice. This wide practice and acceptance of inoculation led it to be sought after by a second generation of Philadelphians after the Revolutionary War. By the 1790s, inoculation was well understood by many Philadelphians—and a second generation of Philadelphia's children were being inoculated.[37]

Many families that had children who had undergone inoculation in the 1750s and 1760s saw to it that their next generation was also inoculated. Elizabeth Drinker carefully noted the inoculations and, after 1802, the vaccinations of her grandchildren for smallpox, and she lectured her sons-in-law about the best method to choose.[38] Benjamin Chew, who had been Chief Justice of the colony of Pennsylvania, was one of Phineas Bond's first clients to seek inoculation for his children. Chew had four of his children and a Negro girl inoculated in May, 1756, and another child and servant inoculated in 1757. In 1790, his son, also named Benjamin Chew, had two children and a Negro girl inoculated, and a year later his daughter was inoculated, all by William Shippen, Jr.[39]

Even less elite families followed this pattern. The Claypooles were a well-known family in colonial Philadelphia. In 1731, smallpox decimated the family of George Claypoole, killing him, four children, and two Negroes. A wife and child survived. In 1734,

---

[37]Inoculation is not mentioned in Irvine Loudon, "The Nature of Provincial Medical Practice in Eighteenth Century England," *Medical History* 29 (1985), pp. 1–32, nor in Loudon's book *Medical Care and the General Practitioner 1750–1850* (Oxford: Clarendon Press, 1986), nor in Joseph F. Kett's "Provincial Medical Practitioners in England, 1730–1815," *Journal of the History of Medicine* 19 (1964), pp. 17–29. Deborah Christian Brinton, in her dissertation, claims that inoculation in Britain led to the decline of elite physicians. See Deborah Christian Brinton, "Pox Britannica: Smallpox Inoculation in Britain, 1721–1830." (Ph.D. diss., University of Pennsylvania, 1992), pp. 3–5, 172.

[38]Cecil Drinker, *Not So Long Ago: A Chronicle of Medicine and Doctors in Colonial Philadelphia* (New York: Oxford University Press, 1937), p. 108; Drinker, *Diary*, vol. 1: pp. 487, 757, 784, 845, 982, 781, 865–66; vol. 2: 931–32, 1157, 1247, 1459, 1137–41, 1147, 1642; vol. 3: 1821.

[39]Bond, Ledger 2, p. 509; Ledger 3, p. 293, CPP. Shippen Papers, William Shippen Jr., Recipe Book, PPAmP; (hereafter cited as Shippen, Recipe Book, PPAmP). Shippen, Document Book, p. 23, DLC.

Matthew Pratt, a grand-nephew of the George Claypoole who died in 1731, was inoculated by Philip Syng, a Philadelphia silversmith. When smallpox struck Philadelphia in 1756, another George Claypoole, a joiner and nephew of the one who died in 1731, and his family were stricken—they were treated by Phineas Bond. By 1765, James Claypoole, a younger half brother of George of 1756, and a painter like his uncle Matthew Pratt, had Bond inoculate two of his children. Claypoole apparently changed doctors, for in 1770 he was the second client of Rush to seek inoculation for his children. Thereafter, from 1770 to 1800, James Claypoole, his son David, his son-in-law James Peale, also a painter and a brother of Charles Willson Peale, were among Rush's most dutiful parents in getting their children inoculated.[40]

Even parents somewhat removed from Philadelphia, and so less likely to be exposed to viral epidemics, sought to get hold of matter for inoculation. In March, 1798, Lambert Cadwalader, living on a family farm near Trenton, sought his sister's help in obtaining the necessary smallpox matter for inoculation. His sister Margaret was living in Philadelphia, where her husband was serving as Treasurer of the United States. He wrote:

> Dear Peggy:
>
> We intend as soon as good Matter can be procured to inoculate Tom for the small Pox and as none could be obtained here, I wrote to Dr. Kuhn to procure me some, but the Dr. could not get it for me at present, alltho' he had applied to several of his medical acquaintances—He thinks however there is a Probability of his getting it among his own patients in the course of ten days—but this will delay the Business longer than I wish, and therefore you will very much oblige me if you will apply to Dr. Rush for it, who may possibly have it in his Power to furnish it—. It is an Encouragement to us to bring it into the Family five of whom are to have it.[41]

---

[40]Franklin, *Franklin Papers*, vol. 1, pp. 200–201; Matthew Pratt, "Autobiographical Notes of Matthew Pratt Painter," *Pennsylvania Magazine of History and Biography* 19 (1895): 460; Bond Ledgers, Ledger 3, p. 150; Ledger 5, p. 210, CPP; Rush, Journal Book 1, pp. 20, 178; Journal Book 4, p. 457; Journal Book 5, pp. 28, 274; Journal Book 6, p. 208; Journal Book 7, pp. 38, 312, 383; Journal Book 8, p. 48; PPL; Rebecca Irwin Graff, *Genealogy of the Claypoole Family of Philadelphia 1588–1893* (Philadelphia, 1893), pp. 52–79, 159–61.

[41]Lambert Cadwalader to Margaret Cadwalader Meredith, March 9, 1798, in Cadwalader Papers, PPAmP.

Over the course of a century, inoculation had transformed smallpox from the dreaded scourge known as "the speckled monster"[42] to a guest encouraged to visit the family's children.

The era of inoculation officially ended in Pennsylvania in 1811 when legislation mandated the use of vaccination.[43] During the eighty years that it had been practiced in Philadelphia, thousands of Philadelphia residents had been inoculated against the disease, as had been countless others like Martha Washington, the Indian leader Little Turtle, twenty-two-year-old Thomas Jefferson, and thousands of others who were considerably more obscure.[44] These years also witnessed the growth and maturation of Philadelphia's medical community. During the colonial era, American cities, Philadelphia included, generally supported approximately one physician per thousand of population, but by the beginning of the nineteenth century the ratio had dropped to one per 800 of population and that was a rate that could be sustained, as some country doctors had 800 families in their accounts.[45] Benjamin Say's account book from 1796–1804 numbered four to five hundred families and approximately 15% of his calls were for inoculation. A young physician like John Syng Dorsey found that in his first two years he inoculated or vaccinated 10 to 20% of his patients and Dorsey was know to have a specialty in surgery.[46] A disease that was once a plague, a scourge,

---

[42]J.R. Smith, *The Speckled Monster* (Chelmsford: Essex Record Office, 1987).

[43]J.M. Toner, "Inoculation in Pennsylvania," *Transactions of the Medical Society of the State of Pennsylvania*, 16th Annual Session, 4th Series (1865): 182.

[44]For Martha Washington, see Joseph Jackson, "Washington in Philadelphia," *Pennsylvania Magazine of History and Biography 56* (1932): 129; for Little Turtle, see Rush, Journal Book 8, p. 299, PPL. Incidentally, he charged the U.S. Government £7 10 shillings to treat Little Turtle for inoculation and gout. For Thomas Jefferson, see Dumas Malone, *Jefferson the Virginian* (Boston: Little, Brown & Company, 1948), pp. 99–100.

[45]On the Philadelphia medical community, see O'Hara, *Emerging Profession*, pp. 16–30; Lisa Rosner, "Thistle on the Delaware: Edinburgh Medical Education and Philadelphia Practice, 1800–1825," *Social History of Medicine 5* (1992): 19–43; Physician ratios discussed in J. Worth Estes, *Hall Jackson and the Purple Foxglove. Medical Practice and Research in Revolutionary America 1760–1820* (Hanover: University Press of New England, 1979), p. 3; Eric H. Christianson, "The Medical Practitioners of Massachusetts, 1630–1800: Patterns of Change and Continuity," in *Publications of the Colonial Society of Massachusetts 57* (1980): 54–56; Evelyn Bernette Ackerman, "The Activities of a Country Doctor in New York State: Dr. Elias Cornelius of Somers, 1794–1803," *Historical Reflections/ Reflexions Historiques 9* (1982), p. 165.

[46]Account Book of Benjamin Say, 1796–1804, CPP; Ledger Book of John Syng Dorsey, 1804–1808, CPP.

a killer and a disfigurer, had now become a planned event (even a source of parties in smallpox hospitals in New England), one whose time and setting could now be arranged.[47] Benjamin Rush offered annual contracts for inoculation in 1792.[48] As doctors could now plan on income from inoculation, patients could choose the time and physician. The elements of planning and choice, the ability to actually prevent disease, rather than just treat it, could lead to contractual arrangements, which for a brief time did occur in Philadelphia in the 1790s.

Beginning in the 1780s some Philadelphia physicians began to experiment with offering annual contracts for their services. This is first observable in John Morgan's account book of the 1780s. According to his biographer, Whitfield Bell, Morgan charged 1 pistole for a first visit as a retaining fee and one dollar thereafter for each visit. Morgan attempted to charge his patients a fee for consultation but was not always successful in doing so. The 1780s accounts indicate that he charged about £1.10 shillings for a month's attendance. He charged the Ingles family 4 guineas for an annual contract in 1781, Isaac Henry and his son 2 guineas each for the year 1783–1784, and at the end of 1784 he charged the Joseph Palmer family 5 guineas a year.[49]

When John Morgan returned from Europe and began practicing in Philadelphia in 1765, his goal had been to institute a pure practice of medicine. He neither wished to do surgery nor dispense medicine. He wanted to write a prescription for his patients for them to fill, and charge them based on his attendance on them. His teacher, John Redman, wrote him before he returned advising him not to institute such changes: "if you begin in the common way you will immediately enter upon a scene of action which will be both honorable & useful, supply all your wants & those dependent upon you and you'll be every way engaged in doing good to rich & poor, and relieving the distress of poor suffering mortals and perhaps receiving daily the blessings of those who are ready to perish, which is better than all the honors or profits of the world, especially if joined with an upright and sympathetic conscience which will make you sleep comfortably; when perhaps the other way might be at-

---

[47]J. Worth Estes and David M. Goodman, *The Changing Humours of Portsmouth: The Medical Biography of an American Town* (Boston: Francis A. Countway Library, 1986), p. 23.

[48]Rush, Journal 7, pp. 54, 61, 62, PPL.

[49]Morgan, Journal C, pp. 9, 204, 286, PHi; Bell, *Continental Doctor*, pp. 153–54.

tended with sleepless nights, aking head or unfeeling heart."[50] Morgan found that his teacher was right and had to dispense medicine, occasionally perform surgery and other tasks not especially to his liking. He inoculated 57 people between 1781 and 1788, most before 1785. He delivered eleven babies and had two other obstetrical cases. Morgan had a small practice of dedicated patients. He saw between two and five patients a day, compared with the twelve a day that Thomas Bond or Benjamin Rush averaged daily. Morgan died in 1789 without realizing that some of his innovations were already being adopted in Philadelphia. It is perhaps ironic that his calls for restructuring medical practice were actually more successfully adopted by his nemesis, William Shippen, in the 1780s and 1790s.

Shippen began offering some annual contracts in 1783. The first that I found was one he offered James Thompson, an innkeeper, in exchange for stabling his two horses. Later in the 1780s and in the beginning of the 1790s, Shippen offered a variety of contracts. He offered James Thompson (presumably the same one) another contract for £35. Other contracts were for seven guineas and for fifteen guineas. These contracts were apart from his obstetrical work.[51]

Benjamin Rush persisted longer than Shippen or Benjamin Say, for that matter, in writing patient accounts in ways that indicated that he charged by drugs dispensed. Rush started making changes in his practice in the 1790s. He began offering annual contracts for inoculation in 1792, charging a group rate for £4.10 for two or more people.[52] During the height of the yellow fever epidemic of 1793, Rush stopped listing medications and just noted visits. He finally adopted that practice for good in 1795. He offered some annual contracts in 1797, and in 1798 started charging for letters of medical advice written to him.[53] Physicians starting out in the 1790s, such as

---

[50]John Redman to John Morgan, March 13, 1764, in Gilbert Collection, CPP, vol. 3, p. 354.

[51]Shippen, Document Book, pp. 58, 58, 134, DLC.

[52]Rush, Journal 7, pp. 54, 61, 62, Accounts of Nathaniel Davis, Andrew Gubble, and Mr. Ashburner, PPL. John Ashburner (1757–1838) was a British-born tanner who settled in Philadelphia, where he married in 1786. By 1792 he had three children and there were eight more to follow. Wilfred Jordan, ed., *Colonial and Revolutionary Families of Pennsylvania*, vol. 7 (New York: Lewis Historical Publishing Co., 1936), pp. 52–53; "Records of Christ Church, Philadelphia," *Collections of the Genealogical Society of Pennsylvania*, vol. 167, pp. 1262, 1282, 1323, 1374.

[53]Rush, Journal 8, p. 237, PPL; account with Mr. Swearingen; accounts with Mr. Edminston and Mrs. Wright, pp. 215, 216, PPL. Benjamin Rush to Richard Bushe, Jr., December 29, 1798, in Lyman Butterfield, ed., *The Letters of Benjamin Rush*, 2 vols. (Princeton: for the American Philosophical Society, 1951, *Memoirs of the American Philosophical Society*, vol. 30), p. 810.

Philip Syng Physick also experimented with annual contracts. Physick began practicing in 1793 and offered his first patients annual contracts of $20 a year for their families' medical care.[54]

Paul Starr noted that these early attempts at providing medical insurance or "contract practice" testified to the weak bargaining position of doctors. They could be exploited, asked to perform unlimited services and generally underpaid and overworked.[55] I think, however, that these attempts at contracts with patients reflects the growth of demand for medical services as inoculation became routine, and other childhood diseases such as measles and scarlet fever became more prevalent. They also gave doctors some control or at least some ability to predict their income, which could otherwise fluctuate wildly from month to month. If extraordinary circumstances arose, they would add to the fee. Contract practice in the South was especially prized.[56] I think that these attempts to have a contractual basis for practice—to borrow a term from Adrian Wilson, to have "a booked doctor" on call—probably did not survive the siege of yellow fever epidemics that plagued Philadelphia from 1793 to 1820.[57]

The one area where contract practice flourished was obstetrics. John Morgan's account book gives some indication of this, but even more revealing are the accounts of William Shippen, Jr. It has long been thought that there are no documentary records left of Shippen's practice in America and the only account we have of his actually delivering babies are the accounts in Elizabeth Drinker's diary of Shippen's service to her daughters, Mary Rhoads and Sarah Downing.[58] There are Shippen accounts, however, and together with the Drinker diary they give a fuller picture of his practice.

There is one medical ledger of Shippen's from 1776 to 1794 in the Shippen Collection at the Library of Congress. Unfortunately, it is not a complete list of patients. One of Shippen's biographers noted

---

[54]Powell, *Bring Out Your Dead*, p. 16.

[55]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1987), p. 63.

[56]Steven M. Stow, "Obstetrics and the Work of Doctoring in the Mid-Nineteenth-Century South," *Bulletin of the History of Medicine* 64 (1990), p. 547.

[57]Wilson, *Making of Man-Midwifery*. See also Irvine Loudon's review of Wilson's book, Irvine Loudon, "The Making of Man-Midwifery," *Bulletin of the History of Medicine* 70 (1996), pp. 507–15.

[58]Betsy Copping Corner, *William Shippen Jr. Pioneer in American Medical Education*, *Memoirs of the American Philosophical Society* 28 (1951), pp. 3–4, 118–22.

that he lacked organizational skill and that is apparent in his records. There is another account book along with this one, which is generally a record of purchases and other business dealings but also has some patient records. The American Philosophical Society owns a small ledger from 1789–1791 entitled Recipe Book, and there is some overlap of patients between the two books. There are also some loose sheets in the back of the Document Book which are midwifery records. Together with the Drinker diary, which contains information on midwifery cases that came later, there are records of 155 obstetrical cases to which Shippen was called.[59] The bulk of the cases date from 1789–1793 when Shippen attended 100 obstetrical cases. The earliest ones pre-date the Revolution, and the last case during which I know he assisted was in 1804. Both in the earliest cases and the 1804 case, at which time Shippen was basically retired, he was called when the patient was in distress. He was assuming the traditional role of the male physician called when a difficult presentation had taken place, a baby had probably died in utero and needed to be dismembered to be delivered, or a post-partum problem such as a retained placenta occurred. Shippen may or may not have attended the birth of Henry Binks (who may have been a footling) in September, 1775, but he attended the mother, Mary Binks, for a variety of post-partum ailments from September though January, 1776. In November, 1775, Shippen was called to deliver the placenta of the wife of the Reverend Mr. Newman.[60] In 1804, he was called by Charles Willson Peale, whose wife had thought it unseemly to have a male physician attend her and carried a post-mature baby until her uterus ruptured. Anyone who reads Peale's account of his wife's death written to her brother, and another letter written by Peale to his sons, would not wonder why women started calling trained (male) physicians to attend childbirth routinely.[61]

---

[59]Randolph Shipley Klein, *Portrait of an Early American Family: The Shippens of Pennsylvania Across Five Generations* (Philadelphia: University of Pennsylvania Press, 1975), p. 123; Shippen, Document Book, DLC; Shippen, Recipe Book, PPAmP.

[60]Shippen, Document Book, pp. 8, 64, DLC. Henry Binks, son of Christopher and Mary was born on September 6, 1775. "Records of Christ Church, Philadelphia," *Collections of the Genealogical Society of Pennsylvania*, vol. 167, p. 869.

[61]Charles Willson Peale to John DePeyster, February 19, 1804, in Lillian B. Miller, ed., *The Selected Papers of Charles Willson Peale and Family* (New Haven: Yale University Press, 1988), vol. 2, pt. 1, pp. 636–37; Charles Willson Peale to Raphaelle Peale and Rembrandt Peale, February 20, 1805, Peale-Sellers Collection, PPAmP.

In a detailed study of childbirth in England, focusing mainly on London, Adrian Wilson demonstrated how in the course of a century (1660–1760) the physician who once was only called in emergencies, started to be called to deliver live babies, and ultimately to be "booked" to attend routine childbirths, replacing the midwife for good rather than just augmenting her skills.[62] This process seems to have been telescoped into a thirty-year period in Philadelphia, rather than following the more protracted process in England.

John Kearsley's account book, with accounts from 1717 to 1731 (and a few to 1736), reveal how infrequently a physician was called to attend childbirth. Kearsley was summoned but twice, once in the middle of the night and once to deliver a dead child. Kearsley charged £3 for this service.[63] By the 1750s the Bond ledgers reveal that not much had changed. The prices they charged had risen to £5 or £6, although they did on occasion charge less, but only on one occasion among the fifteen obstetrical cases recorded in the ledgers does it seem that Phineas Bond had been booked in advance, because he noted a visit and preparation for the delivery of Richardson's brother's wife. Most of the other calls were cases where the doctor was fetched, sometimes in the middle of the night, to assist in an "unnatural," difficult or "preternatural" labor, deliver a retained placenta, or deliver a Negro woman, and here I suppose it was for a slave or servant who did not have recourse to the usual female network that provided midwives, relatives, and gossips.[64]

Soon after Shippen returned from England in 1765, he offered his course in midwifery, which was open to women. Unfortunately, we do not know how successful Shippen's early lectures were or who attended. It seems unlikely that Shippen's lectures changed centuries of tradition overnight. Most women still did not call a physician to attend them in childbirth, except in extreme situations. Drinker never mentioned seeking a physician's help during her own deliveries, and scanty evidence from Shippen's loose papers and Benjamin Rush's journal and day book for this period suggest that, before the Revolutionary War, it was still rare for a physician to be

---

[62]Wilson, *Making of Man-Midwifery*.

[63]Medical Account Book of John Kearsley, DNLM, pp. 147, 199.

[64]Bond, Ledger, vol. 1, pp. 197, 212, 335, 501; vol. 2, pp. 113, 247, 292, 294; vol. 3, pp. 32, 66, 97, 396; vol. 5, pp. 285, 299; vol. 6, entry for Charles Jenkins, June 19, 1766, CPP. See also Catharine M. Scholten, "On the Importance of the Obstetrick Art: Changing Customs of Childbirth in America, 1760–1825," *William & Mary Quarterly*, 34 (1977), pp. 426–45.

booked in advance for childbirth. There are very few instances in Rush's journals of his attending or assisting in childbirth at all, but they all date from 1775 and 1776 and indicate that he, like Shippen and the Bonds, charged £5. Rush, as did Shippen, charged more if his presence was needed day and night or over the course of a few days or months.[65]

By 1780, the situation had begun to change. Between 1781 and 1788, John Morgan delivered eleven babies, attended one miscarriage and one case of puerperal fever. In only one case was he called in the middle of the night to attend a difficult labor. At least eight of the obstetrical cases were regular clients for whom he was called twice in this decade. James Budden used Morgan's services for childbirth and then had him inoculate his children and serve as his family's physician, likewise the Reverend Mr. Blackwell, John Duggan, and James Oellers. In this period Morgan delivered two of Reverend Blackwell's children, and attended Peter LeMaigre's wife in 1785 during her miscarriage and in 1786 during childbirth.[66] Shippen's document book indicates that it was during the 1780s that he began to build a steady practice in midwifery.

Shippen became the regular "accoucheur" to a number of families in the 1780s. His document book uses the term accouchment in most situations in contrast to other terms also used in the document book such as "laying his wife," delivering his wife, or occasionally to attend in lying-in. The impression one gets is that the women for whom he was an accoucheur counted on Shippen attending them and had already reached some kind of agreement for his services, if not a formal contract. Shippen's steady customers in the 1780s included Charles Wharton, whose second wife, Elizabeth Richardson Wharton, apparently died in childbirth or shortly thereafter in 1782. The family genealogy has no mention of a child even though Shippen listed this call as Charles Wharton "accouchment his lady." This did not deter Charles Wharton or his third wife, Hannah Redwood Wharton, from using Shippen's services in 1785, 1787, and 1790. Shippen served as the accoucheur to his cousin, Sarah Shippen Lea, in 1785 and 1789, and delivered six children of Thomas Mackie between 1784 and 1794. Isabella or Arabella King Ryves Ashmead had Shippen called to her bedside at night in October, 1782, but in

---

[65]Rush, Journal 2, pp. 54, 104, 239, PPL; Rush, Daybook 1, Jan. 11, 1775, Jan. 21, 1776, PPL.

[66]Morgan, Journal C, pp. 57, 58, 65, 129, 145, 151, 180, 295, 299, 320, PHi.

October, 1790, she engaged Shippen before the birth of her daughter on October 11, 1790.[67]

Ashmead's second experience with Shippen was noted on a list in back of Shippen's Document Book on a loose sheet called Midwifery Cases and midwifery engagements. He often noted on these sheets when he was first retained by the family to attend the parturient woman. Among his most faithful customers who did engage his services prior to delivery were two of the daughters of Elizabeth Drinker. During Elizabeth Drinker's lifetime, twenty-three grandchildren were born to her. There is no information about the arrangements for five of the births; of the remaining eighteen, Shippen was sought for ten, and delivered seven children all born alive. On the other three occasions he was twice already engaged (once to Sarah Downing when her sister Molly Rhoads was about to give birth) and attending a family funeral on the other occasion. It is not surprising that the Drinker women sought the best help they could get. Drinker recalled that her own labors were often difficult, "ticklish situations," and that two of her daughters were worse than she was. The diary bears that out. Each of these two daughters had one breach presentation: Sarah Downing, called Sally, in 1795, when she was successfully delivered by Shippen; and Mary Rhoads, called Molly, in 1797, when she was delivered by Nicholas Way, a young physician trained by Shippen, but she lost the baby. When Sarah Downing's last child was born in 1799, Shippen told Drinker that the child had been wedged by the pubic bone but was delivered safely without instruments after a very long labor. In 1801, Shippen may have used forceps or manual procedure, like version, to deliver Samuel Rhoads, Molly's son, for Drinker noted that "it had always been

---

[67]Shippen, Document Book, pp. 107, 148 (for Charles Wharton); pp. 45, 71, 138 (for Thomas Mackie); p. 35 (for Thomas Lea); p. 107 (for Ashmead), DLC; Shippen Recipe Book, PPAmP; Anne H. Wharton, *Genealogy of the Wharton Family of Philadelphia 1664 to 1880* (Philadelphia, 1880), pp. 16–17; John H. Campbell, *History of the Friendly Sons of St. Patrick and of the Hibernian Society for the Relief of Emigrants from Ireland* (Philadelphia: Hibernian Society, 1892), p. 121; Klein, *The Shippens*, pp. 152–53. Printed genealogical sources cite Mrs. Ashmead as Arabella; manuscript sources indicate her given name as Isabella. See Frank Willing Leach, *The Ashmead Family* (Philadelphia, 1909) and *Daughters of the American Revolution Lineage Book*, vol. 90 (Washington, D.C.: 1927), p. 111. For manuscript sources, see Shippen, Document Book, DLC, p. 107, and Records of the First Presbyterian Church of Philadelphia, Collections of the Genealogical Society of Pennsylvania, vol. 27, p. 309.

with her and her daughters [that] the child was ready for birth, but there was not enough strength to bring fourth. The doctors supplied a place of Nature." Statistically, only two in one hundred births are thought to present problems like breach presentations or childrens' heads facing the wrong way, but clearly the Drinkers skewed the statistical norm.[68]

The Drinkers generally arranged or booked Shippen in the seventh month of a pregnancy. The Downings booked Shippen in November or December of 1791, for the birth of their daughter Mary on January 22, 1792. For Henry Downing's birth on April 6, 1795, Mary Sandwith, Sarah Downing's aunt, contacted Shippen on January 23, 1795. In May, 1801, six months before Molly Rhoads was due, her mother, Elizabeth Drinker, met with Shippen to discuss her pregnancy. The families also kept a watch on Shippen's movements as due dates grew near. There are comical scenes in the diary of the Drinkers and Shippen meeting on the Germantown Road en-route to Downingtown to check on Sally, only to be told he could go back to Germantown.[69]

Besides long rides through the countryside around Philadelphia, an arrangement with Shippen also meant his attendance both before and after the birth of a child. He checked on Sarah Downing on October 8 and 9, 1789, twice on the 10th, delivered her baby on the 11th (besides seeing eight other patients that day), and checked back on October 13th and October 16th.[70] There were many cases where Shippen noted weeks or months of attendance. All told the Shippen sources, the Drinker diary, and the Peale letters tell of approximately 160 obstetrical cases, and over 100 of those fall between 1789 and 1792. While Shippen is noted for introducing forceps into American obstetrical practice, he seems to have used them rarely, as was the case with his British counterparts. The most noted obstetricians seem to have been very cautious and conservative in the use of forceps. There are only two cases in 1785–1786 where he notes using forceps, and in only one of those does he note the outcome of a live mother

---

[68]Shippen, Document Book, DLC; Shippen, Recipe Book, PPAmP; Drinker, *Diary*, 1: 666–67; 2: 929–30, 931–32, 1096, 1103, 1226–29, 1452; Wilson, *Making of Man-Midwifery*, pp. 15–19.

[69]Drinker, *Diary*, vol. 1: 642; vol. 2: 1209, 1213, 1221, 1409, 1452.

[70]Shippen, Recipe Book, PPAmP.

and child.[71] Shippen clearly had built a very successful specialty in obstetrics, although he was still quite busily employed as a regular physician. His accounts from 1775 through the 1790s also list 200 inoculations.

Shippen died in 1808. By then, man-midwifery had become a normal occurrence even in the countryside of Philadelphia. Drinker's daughter-in-law, Hannah Smith Drinker, was attended by rural or suburban practitioners like Lewis Jardine and Reading Beatty. William Darlington of Chester County attended 117 births between 1806–1812.[72] Drinker was mildly scandalized that her daughter Nancy only had midwives attend two of her daughter's births, and constantly fretted about and criticized their skills or lack thereof.[73] And while there is ample evidence that the female midwife tradition continued in Philadelphia through mid-century,[74] it is clear that, by 1810, male physicians were routinely delivering hundreds if not thousands of Philadelphians.

Smallpox vaccination and male-midwifery were the two major innovations in medical practice in Philadelphia from 1730 to 1810. Both of them enhanced the power and status of regular physicians but also provided consumers with the ability to choose a physician for a variety of services and perhaps establish a price. Many people sought Shippen's services for childbirth, while almost no one sought Rush, although Rush was sought after for contracts to treat "lunatics" at Pennsylvania Hospital.[75]

Very briefly, I would like to suggest or speculate on why the shift to male-midwifery took place so quickly in comparison to England or even in comparison to the adoption of inoculation in Philadelphia. I think the female rituals surrounding childbirth, particularly the religious role granted the midwife as godmother, were

---

[71]Irvine Loudon, "Deaths in Childbed from the Eighteenth Century to 1935," *Medical History* 30 (1986), pp. 18–19; Porter & Porter, *Patients' Progress*, pp. 180–83; Shippen, Document Book, pp. 56, 149, DLC.

[72]Paul Berman, "The Practice of Obstetrics in Rural America, 1810–1860," *Journal of the History of Medicine and Allied Sciences* 50 (1995), p. 178. See also, Amalie M. Kass, "Called to Her at Three O'Clock AM." Obstetrical Practice in Physician Case Notes. *Journal of the History of Medicine and Allied Sciences* 50 (1995), pp. 194–229.

[73]Drinker, *Diary*, vol. 2, p. 1437.

[74]Rosner, "Thistle on the Delaware," p. 35.

[75]Rush, Journal Book 5, PPL.

severely attenuated in the New World, particularly in the radical Protestant environments of Congregational New England or the Quaker communities in and around Philadelphia. The midwife's role at church and church rituals were severely limited or eliminated in these areas.[76] This is less true for groups like the German Lutherans, Dutch Reformed and Huguenots in New York, and may help explain Elizabeth DePeyster Peale's reluctance to call in a male physician in 1804.

Secondly, in Philadelphia and places like Boston or Portsmouth, New Hampshire, places where this shift to male physicians routinely attending childbirth occurred at roughly the same time as it did in Philadelphia, the women coming of age in the generation from 1780–1810 were the first large cohort of children to have been inoculated for smallpox.[77] They and their parents had already experienced and participated in a fundamental restructuring of doctor-patient relationships. Doctors could now be called on to prevent a disease or to insure a good outcome and not just attend medical emergencies. They could be called for a pre-arranged time, to provide a known or planned service. If you had the means and knowledge, you could choose different doctors for different services. This experience reinforced the advice that domestic manuals, like Buchan's, dispensed both in regard to childbirth and inoculation. Buchan's *Domestic Medicine* first became available in Philadelphia in 1772, when inoculation had already been widely accepted. Buchan supported inoculation, as did his Philadelphia editors in their revised editions of the 1790s. Buchan, like his Philadel-

---

[76]Jane B. Donegan, " 'Safe Delivered,' but by Whom? Midwives and Men Midwives in Early America," in Judith Walzer Leavitt, ed., *Women and Health in America* (Madison: University of Wisconsin Press, 1984), pp. 302–317; M.D. Learned and C.F. Brede, eds., "An Old German's Midwife's Records (kept by Susanna Muller of Providence Township, Lancaster County, Pennsylvania during the years 1791–1815), pamphlet owned by CPP; Anna Giardina Hess, "Midwifery Practice Among the Quakers in Southern Rural England in the Late Seventeenth Century," in Hilary Marland, ed., *The Art of Midwifery. Early Modern Midwifes in Europe* (London: Routledge, 1993), pp. 49–76. See also in the same volume essays by Merry E. Wiesner on the midwives of South Germany, Nadia Maria Filippini on midwives in Italy, and Hilary Marland on midwives in Holland.

[77]Estes, *Hall Jackson*, pp. 16–22, 119; J. Worth Estes, "Therapeutic Practice in Colonial New England" for William Aspinwall's career in Boston, and Philip Cash, "The Professionalization of Boston Medicine, 1760–1803," both in *Medicine in Colonial Massachusetts, 1620–1820. Publications of the Colonial Society of Massachusetts*, 57 (1980), pp. 294–302, 75–76, 91–92, 94.

phia adaptor, Isaac Cathrall, was also very critical of midwives.[78]

Thirdly, the socio-economic and cultural forces that created a market for books like Buchan's and the leisure and reading culture that provided an audience for these works also created the circumstances that supported the birth of medical journalism. Roy Porter and W.F. Bynum's work in England detail the birth of medical publishing and journalism there and many of the works were also available or republished in the United States. The first American medical journal began publication in New York in the 1790s, followed shortly thereafter by publications in Philadelphia and Boston.[79] The market for medical publications also publicized and extended the knowledge of new technology in childbirth—that is, forceps, vectis, better techniques of version, and the advances in anatomy by people like William Smellie, John Hunter, and William Potts Dewees.[80] A combination of technical innovation, the cultural and social shifts that created acceptance of these innovations and ultimately demanded their use, and the scientific understanding to support its use all reached American shores within a thirty-year period and contributed to the rapid adoption of "male-midwifery."

After 1810, the male-midwife, accoucheur, obstetrician, became a standard feature of American medical practice. Many female midwives continued to practice, but for growing numbers of (white) women, attendance by a trained physician became the norm. Samuel Gross, a famous nineteenth-century surgeon, said of William Potts Dewees, who was the pre-eminent obstetrician in Philadelphia in the

---

[78]Wolman, "Community Health," p. 157; William Buchan, *Domestic Medicine or the Family Physician* (Philadelphia: John Dunlap, 1772), pp. 148–68; for Buchan's remarks critical of midwives, see Rosenberg, "Medical Text and Social Context," pp. 27–28 and Murphy, *Enter the Physician*, p. 42; see also Isaac Cathrall's footnotes in William Buchan, *Domestic Medicine: Or, a Treatise on the Prevention and Cure of Diseases by Regimen and Simple Medicines Adapted to the Climate and Diseases of America, by Isaac Cathrall* (Philadelphia: Richard Folwell, 1797), p. 363n. Cathrall and Samuel Powel Griffitts each adapted Buchan's *Domestic Medicine* for Philadelphians in the 1790s. Isaac Cathrall's comments on inoculation can be found on pp. 174–182 in the above cited edition. For Samuel Powel Griffitts, see William Buchan, *Domestic Medicine: Or, A Treatise on the Prevention and Cure of Diseases . . . revised and adapted to the Diseases of the United States of America by Samuel Powel Griffitts, M.D.* 2nd ed. (Philadelphia: Thomas Dobson, 1797), pp. 237–49, 539.

[79]Porter, "Medical Journalism"; Porter, "*Gentleman's Magazine*"; Porter & Porter, *Patients' Progress*, pp. 197–204; Richard D. Brown, *Knowledge Is Power. The Diffusion of Information in Early America, 1760–1865* (New York: Oxford University Press, 1989), pp. 185, 188–89; Norman Gevitz, " 'But all those authors are foreigners.' American Literary Nationalism and Domestic Guides," in Roy Porter, ed., *The Popularization of Medicine 1650–1850* (London: Routledge, 1992) pp. 232–51; James H. Cassedy, "The Flourishing Character of Early American Medical Journalism," *Journal of the History of Medicine and Allied Sciences* 38 (1983), pp. 135–38.

[80]Loudon, "Deaths in Childbed," pp. 18–19; Loudon, "The Making of Man-Midwifery," p. 513.

first third of the nineteenth-century, "no woman of any social position in Philadelphia considered herself safe if she could not have Dewees in her confinement."[81] Yet at the same time vaccination languished. Because it had been so successful earlier, doctors and patients often forgot about it. It was difficult to obtain the vaccine and keep it pure. James Langstaff, a well-educated physician practicing outside of Toronto, vaccinated only about 10% of the babies he delivered. His carelessness about smallpox nearly cost him the life of his nephew and student in the 1870s.[82] Attacked by irregular practitioners, vaccination laws were overturned or weakly enforced. As late as the 1890s, there were epidemic outbreaks of smallpox in American cities.[83] The different paths traveled by physician-managed births and vaccination in the nineteenth-century can be ascribed to differences in scientific understanding. The medical and anatomic problems that could be presented by pregnancy and childbirth were well understood by many nineteenth-century physicians and their literate patients. How vaccination worked was not. Until the discovery of the germ theory, and later developments like diphtheria toxin, vaccination was something of an isolated and erratic phenomenon.[84] Society's demand for vaccination would ebb and flow with epidemic outbreaks. Its use as a standard feature of practice in preventive medicine skipped from the eighteenth century to the twentieth century.

We do know that inoculation and vaccination did work. They did save lives and contribute to declines in mortality. They removed smallpox from the ranks of major causes of death from epidemic disease in the United States during the nineteenth century, even if their universal adoption has a checkered history. They ushered in an new understanding of the role of the physician and his relationship to his patients. He and later she could prevent disease, could be booked or reserved for medical procedures, and could be contracted for specific services, or to serve as a family's practitioner. These opportunities had not been available to Elizabeth Sandwith's mother or to George Claypoole, but they were for their children and grandchildren in Philadelphia and its environs a half-century later.

---

[81]Stefan C. Schatzke, "Dr. Dewees," *American Journal of Roentgenology*, 159 (1992), p. 932.
[82]Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), pp. 230–31.
[83]Martin Kaufman, "The American Anti-Vaccinationists and their Arguments," *Bulletin of the History of Medicine*, 41 (1967): pp. 463–78; Judith Walzer Leavitt, "Politics and Public Health: Smallpox in Milwaukee, 1894–95," *Bulletin of the History of Medicine*, 50 (1976), pp. 553–68.
[84]Starr, *Transformation*, pp. 137–38.

Photograph of S. Weir Mitchell, M.D. (1829–1914)
Collection of the Library of the College of Physicians of Philadelphia

A Nineteenth-Century Literary Physician: S. Weir Mitchell's Medical Work and Imaginative Writing

Nancy Cervetti[1]

It would be difficult to overestimate the influence of S. Weir Mitchell on nineteenth-century medicine, women, and American culture in general, an influence few if any other nineteenth-century American doctors achieved. Certainly, his long and productive life is impressive. At the age of twenty-three he published his first scientific article in the *American Journal of the Medical Sciences*. In addition to the 170 other papers and addresses which followed, Mitchell published several medical books for doctors and lay readers, a controversial biography of George Washington, children's stories, numerous short stories, several books of poetry, and thirteen novels. French and American physicians still used his book, *Injuries to the Nerves and Their Treatment*, during World War I. Mitchell's study of rattlesnake venom laid the foundation for subsequent research in toxicology and immunology. He also established one of the largest medical practices in Philadelphia, the nation's medical center at the time. In a 1908 letter to Owen Wister, Mitchell noted that he had made sixty-four thousand dollars during one year, which would be equal to well over a million in today's dollars.[2]

During the 1870s Mitchell introduced his trademark method of treatment, the rest cure, especially for women suffering from hysteria and neurasthenia. The regimen included isolation, bed rest, massage,

---

[1]A version of this paper was originally presented in March 1997 at a seminar sponsored by the Francis Clark Wood Institute for the History of Medicine at the College of Physicians of Philadelphia. Most of the research was done during a fellowship at the Wood Institute. I am especially grateful to the College's archivist, Charles Greifenstein, for his help.

[2]Anna Robeson Burr, *Weir Mitchell: His Life and Letters* (New York: Duffield & Co., 1929), p. 121. According to the consumer price index conversion factor of 0.06, $64,000.00 in 1880 would be $1,066,666.66 in 1996. See "Consumer Price Index Conversion Factors to Convert to 1996 Dollars," available on *http://www/orst.edu/Dept/pol_sci/sahr/cpi96.htm* on October 4, 1998.

electricity, and a fattening diet. The rest cure was adopted in Great Britain and Europe as well as in the United States. Jane Addams, Alice James, Charlotte Perkins Gilman, Edith Wharton, Winifred Howells, and Virginia Woolf (on four occasions), along with thousands of other women, followed some form of it.[3] Gilman wrote "The Yellow Wallpaper" to capture the experience. She stated that the real purpose of her story was to reach Dr. Mitchell and "convince him of the error of his ways. I sent him a copy as soon as it came out."[4] Mitchell's ban on reading and writing was particularly difficult for patients like Gilman and Woolf. Because women textualized their encounters with the cure, it became part of the cultural fabric and played an important role in literary history by shaping the themes in women's writing. A number of works embody the struggle between going to bed—a kind of symbolic or literal death—and achieving a life of artistic expression and selfhood.[5]

When Mitchell married his second wife, Mary Cadwalader, in 1874, he moved from the middle class into Philadelphia's most elite social circle. By then his practice was enormous and he had published extensively on numerous medical and scientific topics. He had two sons and a daughter and an active social and civic life. He was, however, not totally satisfied. At the age of fifty-one he began to publish literature under his own name, announcing that he had commenced the practice of his "second profession." Not only did he begin to write literature, but he invested his writing with the same authority, legitimacy, and moral purpose he brought to his medical work.

In his letters, essays, and addresses, Mitchell often spoke about the relationship between his medical work and literary writing. It is clear that he felt that they formed a fruitful union, a rich and mutually supportive partnership. His ample remarks provide an occa-

---

[3]Mitchell, himself, referred to the "thousands of cases of many forms of neurasthenia and allied disorders successfully treated by rest." See "The Treatment by Rest, Seclusion, Etc., In Relation To Psychotherapy," *JAMA*, L (1908), p. 2037.

[4]Charlotte Perkins Gilman, *The Living of Charlotte Perkins Gilman: An Autobiography* (New York: Arno Press, 1972), p. 121.

[5]For examples of such works, see Mary Austin, *A Woman of Genius* (Old Westbury, N.Y.: Feminist Press, 1985); Edith Wharton, *The House of Mirth* (New York: Penguin, 1985); Virginia Woolf, *The Voyage Out* (New York: Harcourt, Brace, & Jovanovich, 1948); and Elizabeth Von Arnim, *The Pastor's Wife* (Boston: Charles E. Tuttle, 1993). For a comprehensive discussion of hysteria, see Tom Lutz, *American Nervousness 1903* (Ithaca: Cornell University Press, 1991). For an insightful analysis of the relationship between hysteria and feminist writing, see Diane Price Herndl, "The Writing Cure: Charlotte Perkins Gilman, Anna O., and 'Hysterical' Writing," *NWSA Journal* 1.1 (1988), pp. 52–74.

sion for exploring the relationship between medical work and literature in terms of motivation, ideology, imaginative power, and methodology.

Mitchell grew up in a home where medicine and literature were both highly regarded. There were nine children in the family, and reading and discussing literature were integral parts of family life, especially at dinner. The dining room doubled as a library, with book-shelves lining the walls: "Around us at meals were some two thousand books and often someone would quit the meal to find a book and triumphantly refute the adversary. Most of our talks were literary or of travel, history, etc."[6] His father wrote poetry and was particularly fond of eighteenth-century British poets. Mitchell remembered being "early taught" to use encyclopedias, to talk at meals and to read aloud (AB, p. 57). In the Mitchell household, family discussions and conversations with friends moved easily from medical issues to literary topics.

While Mitchell grew to value both medicine and literature, a certain degree of ambivalence characterizes his discussions of the place and purpose of literature in a physician's life. In his unpublished autobiography, he wrote that, as a young boy, literature held sway and that he chose medicine as a career out of practical necessity rather than a sense of vocation (AB, pp. 91–94). When he became a doctor, he suppressed his literary activities, publishing only a few literary pieces and nothing under his own name. Once firmly and powerfully established, however, he refashioned himself as a fiction writer, giving more and more thought to his research and writing. Nonetheless, he frequently belittled literary activities in relation to medical work. He also relied on his position as a medical professional to legitimize his literary pursuits and to endow them with a special kind of prestige. However, it is clear that the writing he did, especially of his novels, intensified in importance, making more and more demands on his energy, time and concentration.

Throughout his lectures and letters, Mitchell identified a number of specific reasons why medicine and literature were mutually beneficial. In 1899 he wrote to Dr. George M. Gould, "I believe that my medical opportunities have been of great value to me as a writer of fiction, and in every one of my books will be found a picture of

---

[6]S. Weir Mitchell, Autobiography, S. Weir Mitchell Papers, College of Physicians, Philadelphia, Box 16, Series 7.1, Folder 2, p. 82. Subsequent citations from the Autobiography are incorporated parenthetically in the text and are identified as AB followed by the page number.

some form of disease." He added that the "literary M.D. is one who still adheres to & honours his profession and even relates the two things. My own medical experience has been in my novels invaluable and they have had—success, as a test, in so many editions."[7] Still, Mitchell always referred to medicine as his first profession, dividing his activities into scientific work, clinical labors, and "literary play in the summer." Medicine granted him the power to speak with authority and confidence, while literary work strengthened his voice and supplied its clarity. He spoke of writing as "mental gymnastics" and wrote in *Two Lectures* that the "use of the pen is for many minds needed to give definition to thought. For me this has always been the case, and whether it be a mere literary statement or a problem in toxicology or medicine, it only grows clear to me on the written page, and perhaps only then after repeated efforts to put it in words."[8] The word "mere" again points to his tendency to assign a secondary status to literature in his discussions of the literary physician.

Mitchell explained the value, to physicians, of writing literature in his *JAMA* article on the poetry of Dr. Ronald Ross. Ross had won the Nobel Prize for proving that mosquitoes transmitted malaria and Mitchell began with the epigram from Ross's book: "These verses were written in India between the years 1891 and 1899, as a means of relief after the daily labors of a long, scientific research."[9] Like Ross, Mitchell believed that changing the nature of one's mental activities rested and refreshed the mind. Reading and writing literature broadened one's charity, tolerance, and empathy and therefore enhanced a doctor's ability to deal kindly and gently with patients. He even criticized Darwin for abandoning the literary side of his nature, explaining:

> I am sure that in the end he was a worse scientific instrument by reason of his acquired indifference to all that lies within the bounds of one vast continent of human product. . . . It is a common defect in men of science. . . . The mind, like the body, is of complex build. For perfect health of either we need exercise of all its parts. (MP, 17, 7.2, 29)

---

[7]S. Weir Mitchell Papers, College of Physicians, Philadelphia, Box 8, Series 4.2, Folder 6. Subsequent citations from the Mitchell Papers are incorporated parenthetically in the text, identified as MP followed by the box, series, and folder numbers.
[8]Mitchell, *Two Lectures on the Conduct of Medical Life Addressed to the Students of the University of Pennsylvania* (Philadelphia: University of Pennsylvania Press, 1893), p. 29.
[9]Mitchell, "The Literary Side of a Physician's Life—Ronald Ross as a Poet," *JAMA* XLIX No. 10 (1907), p. 852.

For Mitchell, literary activity, because it took place in a different area of the brain from medical work, constituted a type of mental exercise that allowed the important work of science and medicine to be pursued more competently.

In the preface to the catalogue of his works, Mitchell began: "The following list of books and essays, whether medical or literary, represents as to the former the work, and as to the latter the play, of the years between 1851 and 1894." The catalogue contained

> a full list of all my novels, essays, and poems [omitting numerous magazine articles]. These works may serve at least to show that it is possible for a man weighted with the gravest interests of scientific medicine to employ his imagination. Also, it may help to prove that with us, at least, the great public is indulgent when satisfied that such use of leisure has in no way lessened a man's practical usefulness. (MP, 17, 7.5)

After installing a strict boundary, Mitchell came down heavily on the side of scientific medicine as grave and worthwhile. Literature was romantic and somewhat excessive. Writing to Dr. Harvey Cushing in 1904, Mitchell commented on the abrupt transition he experienced from summer literary play to winter medical practice:

> I often reflect with some interest on the influence upon a man of sudden changes of occupation. On my return home I find myself fully taken up by patients and consultations, and by more or less of public duties connected with institutions. I think I could no more have written the Lycian Tomb in winter than I could have flown. I wonder how many men we are, after all. (MP, 8, 4.2, 3)

Mitchell identified context and daily rhythm, along with public expectations and demands on his time, as factors that determined his performance.

Yet, in contrast to his usual characterization of literature as play, in his lecture to liberal arts students, Mitchell defended literary work, especially poetry, as essential and difficult, equating the mental labor needed for poetry with that of science (MP, 17, 7.2, 29). This difference in emphasis, I will argue, has more to do with Mitchell's ambiguous feelings regarding medicine and literature than with the composition of his audience. Confusion and contradiction emerge in various ways. The actual process of Mitchell's literary production belies his repeated references to medicine as serious work and literature as "leisure" and "play."

Although Mitchell was called a pioneer in medicine and a conservative in literature, this clean distinction is undermined by his self-conscious and complex use of detail. In his literary projects, Mitchell vehemently rejected the naturalism and realism of his day, stating that the straining after realistic precision often injured the larger purpose of fiction or drama. He added, "If there is one literary label I hate more than another, it is the word Realist" (MP, 17, 7.2, 31). In his lecture on "Novels and Novelists," Mitchell referred to books that were "needlessly painful, distressingly horribly," using *Tess of the D'Urbervilles* as an example and referring to "the realistic atrocities of Zola, and even Tolstoi" (MP, 17, 7.2, 18). In his eulogy of Mitchell as a literary writer, Owen Wister explained:

> It is preposterous to suppose that any Balzac or Flaubert or de Maupassant knew more of evil and sorrow and pain than Dr. Mitchell. Four years of mutilated soldiers and fifty of hysteria, neurosis, insanity, and drug mania, unrolled for him a hideous panorama of the flesh of the mind and the soul. But when in one of his books he makes a Doctor say: "Who dares draw illness as it is? Not I," he gives the clue to his fiction. . . . His novels abound with studies of decay. *Hugh Wynne* and *Circumstance* offer us senile change; *Roland Blake*, hysteria; *Far in the Forest*, the insanity of persecution; *In War Time* and *Constance Trescott*, the progressive moral rotting of their chief characters. . . . But these studies are not hostile; the author does not take open or secret pleasure in the ills wherewith the face of man is blackened. Consider what we should have had if Balzac or Flaubert or Zola had known what Dr. Mitchell knew about women? (MP, 1, 1.1, 3)

Mitchell strongly cautioned against a realistic portrayal of sickness in literature, writing: "Depend upon it, the novelist had better fight shy of the realities of illness, if he means to preserve the entire decorum of his pages. Here no man may dare to be realistic" (AB, pp. 39–40).

As a clinician, however, Mitchell promoted an intimate relationship between doctor and patient, stressing the importance of patients talking and recovering their histories as part of the cure. One of his colleagues, Dr. W.W. Keen, said that Mitchell "taught me how to observe and how to elicit, often literally to 'dig up,' histories from unobservant patients" (MP, 1, 1.1, 3). Mitchell focused on details, case histories, and the talking cure and recognized, unlike many other nineteenth-century neurologists, the connection between physical

and mental health. About "women who have been made by disease, disorder, outward circumstance, temperament, or some combination of these, morbid in mind," he wrote:

> Above all, the man who is to deal with such cases must carry with him that earnestness which wins confidence. None other can learn all that should be learned by a physician of the lives, habits, and symptoms of the different people whose cases he has to treat. . . . The priest hears the crime or folly of the hour, but to the physician are oftener told the long, sad tales of a whole life, its far-away mistakes, its failures, and its faults. None may be quite foreign to his purpose or needs. The causes of breakdowns and nervous disaster, and consequent emotional disturbances and their bitter fruit, are often to be sought in the remote past.[10]

At the same time, Mitchell was fully aware that he concealed such detail in both his medical and literary writing. For example, in his *JAMA* article on treatment by rest, he wrote, "I find myself stating a case; I meant to confine myself to unpicturesque generalities"; and "I have seen some rather appalling results from hypnotism, but there again I avoid detail."[11]

The requirements of gentility played a crucial role in Mitchell's life. Propriety, an androcentric perspective, and the idealization of women as the "angel in the house" constituted the driving ideological forces behind his methodology. Working deductively, he strove to shape and rebuild character according to his ideals. Whether treating neurasthenic women or creating fictional characters, Mitchell designed ways to maintain the status quo rather than change the environment. He conceptualized women as "pre-eminent for affection, sympathy, devotion, self-denial, modesty, long-suffering or patience under pain, disappointment, and adversity, for reverence, veneration, religious feeling, and general morality."[12] In his view, women should live to serve and reproduce. They belonged at home where, with their sweetness, they nurtured children and cherished and accommodated their husbands. Because realism might obscure or detract from his didactic purpose, Mitchell excluded from his medical and literary writing the very details so crucial to his clinical practice.

---

[10]Mitchell, *Doctor and Patient* (Philadelphia: Arno Press Inc., 1887), pp. 9–10.
[11]Mitchell, "The Treatment by Rest," p. 2036.
[12]Mitchell, *Doctor and Patient*, p. 138.

Even though the realistic details he elicited from patients do not appear in his novels, Mitchell's desire for control is evident in both his clinical recommendations and his writing. In his medical books, Mitchell wrote that the doctor must control neurasthenic patients with "a firm and steady will." The doctor's highest duty was to alter the "moral atmosphere" and to administer "moral medication."[13] His goal was to send a woman "home changed no less morally than physically," so that she could resume "her place in the family circle and in social life, a healthy and well-cured woman."[14] Similarly, in his novels, Mitchell self-consciously controlled each scene. Rather than mirroring or transforming reality, he viewed his novel writing as the cultural work of curing society's ills by reflecting, maintaining, and justifying appropriate moral behavior and social policy. Success and failure were meted out according to his personal beliefs and code of ethics. Through his characters' motives, their dialogue, and the presentation of their neurotic personalities, Mitchell presented a sanitized version of his medical and social world. A brief description of two of Mitchell's novels, *Westways* and *Characteristics*, will illustrate his methodology.

In addition to presenting directions for the proper social construction of gender, *Westways* justifies the need for distinct gender roles. Although Mrs. Ann Penhallow is totally devoted to her husband, she disagrees with Mr. Penhallow regarding the slave question. As a result, they have simply decided not to discuss politics, and Ann tells her niece, "I do not see why girls should be discussing politics."[15] Mr. Penhallow states, "women ought not to think. Now if my good Ann wouldn't think, I should be the happier." Placing an affectionate hand on Penhallow's arm, the local rector adds, "my dear Mrs. Penhallow doesn't think, except about the every-day things of life. Her politics and religion are sacred beliefs not to be rudely jostled by the disturbance of thinking."[16]

When *Westways* begins in 1856, Penhallow Mills, the family business, is floundering. Ann has contributed $50,000 from her own fortune to sustain it through these difficult times. Once the Civil War begins, the Secretary of War signs a contract with Penhallow

---

[13]Mitchell, *Lectures on Diseases of the Nervous System, Especially in Women* (Philadelphia: Henry C. Lea's Son & Co., 1881), p. 228.
[14]Mitchell, *Fat and Blood: and How to Make Them* (Philadelphia: J.B. Lippincott & Co., 1844), p. 90.
[15]Mitchell, *Westways* (New York: Century Co., 1914), p. 250.
[16]Ibid., p. 76.

Mills for field artillery. While Mr. Penhallow is joyous, triumphantly announcing the contract at dinner, Mrs. Penhallow, the descendent of a prominent Maryland family, breaks down, laughing "hysterical laughter" and crying, "you are to make cannon—you—and I—and with my money! . . . to kill my people the North has robbed and driven into war and insulted for years."[17] Referring to this scene as a "performance," the town doctor blames Penhallow for coddling his wife, saying, "My old Indian guide used to say, 'Much stick, good squaw.' Ann Penhallow has never in her whole life had any stick. Damn these sugar plum husbands!" The diagnosis is "pure hysteria"—a "suicide of reason"—and Mrs. Penhallow is sent to bed in a dark room; Penhallow is "mercifully spared the sight of the drama of hysteria."[18] Eventually, through the rest cure, she recovers, while her husband sells his share in the mill and goes to war.

Returning with a head injury, Penhallow makes a full recovery and resumes his place as patriarch. Ann has already resumed her proper place, declaring:

> "What do I care for Lee—or Meade—or battles! James Penhallow is all the world to me. Victory!"—she flamed with mounting colour—"it is I am the victor! He comes back with honour—I have no duties—no country—I have only my love. . . ." She spoke with harsh vehemence, and of a sudden stopped, and breathing fast gasped in low-voiced broken tones, "Don't stare at me—I am not a fool—I am—I am—only the fool of a great love. You don't know what it means. My God! I have no child—James Penhallow is to me children, husband—all—everything."[19]

Earlier in the novel, the rector had informed Penhallow that the "general trouble about understanding women is that men judge them by some one well-known woman. I heard a famous doctor say that no man need pretend to understand women unless he had been familiar with sick women."[20] This famous doctor is, of course, Mitchell himself, who wrote in *Doctor and Patient*, "the man who does not know sick women does not know women."[21]

---

[17]Ibid., p. 310.
[18]Ibid., p. 315.
[19]Ibid., p. 386.
[20]Ibid., p. 254.
[21]Mitchell, *Doctor and Patient*, p. 10.

In the novel *Characteristics*, Dr. Oliver North and Alice Leigh, who is twenty-four and desirous of serious work, are discussing the topic of women and medicine:

> [Dr. North:] "I think that every human being, man or woman, is entitled to any career he or she may please to desire. This is a mere human right."
>
> "Oh, thank you."
>
> "Wait a little. Whether the public will use the person or not, is the business of the public. Should you ask if personally I believe that women make as good doctors as men of like education, I say no. Should you ask me if I think it desirable that in the interests of society in general women should follow the same careers as men, I say no."
>
> "And why?" . . .
>
> "I never saw a woman who did not lose something womanly in acquiring the education of the physician. I hardly put it delicately enough: a charm is lost."
>
> "Oh, but that is of no moment."
>
> "You cannot think that. You would lose the power to know you had lost something. That is the real evil. Others would know it. Men, at least."[22]

The doctor's words have their effect. Rather than find meaningful work, at the novel's close Alice Leigh professes her love for Dr. North, and they appear as a married couple in *Dr. North and His Friends*, Mitchell's autobiographical novel and the sequel to *Characteristics*.

In 1896 Agnes Irwin, Mitchell's friend and the Dean of Radcliffe College, asked him to address the Radcliffe students. Like Dr. North in *Characteristics*, Mitchell acknowledged the right of women to choose a vocation, but he added, "I no more want them to be preachers, lawyers, or platform orators, than I want men to be seamstresses or nurses of children."[23] He ended the address with the hope that "no wreck from these shores will be drifted into my dockyard. Sometimes I can re-fit the ruined craft. Alas, sometimes I cannot!"[24] Mitchell's biographer, Anna Robeson Burr, explained that for years his knowledge had come from seeing women as patients

---

[22]Weir Mitchell, *Characteristics* (New York: Century Co., 1900), pp. 251–52.
[23]Mitchell, "Address to the Students of Radcliffe College" (Radcliffe College Library, Cambridge, 1896), p. 6.
[24]Ibid., p. 23.

and this fact "naturally colored his attitude toward her and her problems. Inevitably, he came to associate her with weakness, till the association crystallized into a cliché." Burr noted that his attitude never changed: "Even in later years, when certain friends and colleagues tried to show him that further knowledge had come to change the statistics in these matters, he obstinately clung to his own view."[25] In *Doctor and Patient,* Mitchell wrote that careers "inevitably lessen her true attractiveness, and to my mind make her less fit to be the 'friendly lover and the loving friend.' . . . For most men, when she seizes the apple, she drops the rose."[26] It is ironic that while many of his patients were struggling against this very ideal, Mitchell was working to return them to complete domesticity.

It appears that literature for Mitchell was not really play or leisure activity but rather an early and significant attachment that reemerged, once his professional reputation was secure. It served the same purpose as his medical work—a kind of psychological treatment and therapy, reinforcing strict gender roles, with women, in the end, tamed and submissive.

In the following excerpts addressing the process of writing, Mitchell described his literary activities—the discipline, concentration, and emotional investment in terms that are usually associated with serious work rather than play. About the early stages of *Hugh Wynne*, he wrote:

> For many years I had spent a good deal of my small leisure, in the library of the Historical Society, collecting material for a book. At last, after some six or seven years of thought and collection of material, I had about a hundred pages of notes . . . . (AB, pp. 177–178)

In a letter to a professor teaching *Hugh Wynne* in a history seminar, Mitchell discussed his sources and method:

> I used Watson's *Annals of Philadelphia*, but with great care, as the book is extremely unreliable. I made much more use of diaries of the times, as Miss Drinker's, Christopher Marshall, Shoemaker, and others. I also read enormously for years, letters of the time published and unpublished, and books relating to the period, which of course are open to any one. One of the

---

[25]Anna Robeson Burr, *Weir Mitchell: His Life and Letters* (New York: Duffield & Co., 1929), p. 373.
[26]Mitchell, *Doctor and Patient*, pp. 139–40.

> most valuable to me was Barker's Itinerary of Washington during the War. Also I was much helped by the interesting letters (unpublished) of Col. Bradford, Dr. Rush, and Wilson. I ought to add that I was over seven years preparing myself to write this book. This may give your young students an idea of the care necessary to reach certain ends. Every important chapter, save one, in the book was rewritten three or four times. (MP, 10, 4.4, 11)

About his poetry, he wrote, "Of verse, why I cannot say but all my best verse has been long in my mind in time . . . and, like all verse for me, hard labor" (AB, pp. 187–88). About his books in general, he wrote, "to all of them I have given an amount of labor which I think unusual" (AB, p. 181). He worked for three years on *Constance Trescot*, a novel in its "5th copy when it went, the other day, to the Century for their decision" (AB, p. 181). He added:

> I ought to say that I have three times printed four or five copies of this and of one or two other books before finally considering them, since to see a book in print is to enable you to exercise powers of criticism which sometimes fail, at least for me, when the book is typewritten or in manuscript. (AB, p. 182)

The careful revisions, the amount of research, time, and the concern with which Mitchell handled his novels resembles the way a doctor handles a patient, proving the seriousness of the work and the importance of the outcome.

Another set of letters, written in 1907, which Mitchell included as part of his autobiography by numbering the pages accordingly, sheds particular light on the importance of the relation between his medical work and writing. Dr. R.S. Woodward had asked Mitchell for information regarding "the operations of mental machinery." In his description, Mitchell associated the process of scientific research with the process of writing literature. Using similar words and describing similar activities, he wrote about his research with snake venom:

> The process is not very unlike that which is present when in fiction or verse you wait, watching the succession of ideas which come when you keep an open mind. It seems to me then that my scientific research means immense curiosity, the formation and rejection of hypotheses, of which my mind is very fruitful, the testing of these experimentally and above all unfailing energy. (AB, p. 167)

He also saw the writing of poetry as an intense process of formation, rejection, and selection:

> a matter of continual summoning of thoughts, clothing them in suitable language, accepting or rejecting them as unfit, not original, or in some shape unsuitable with ever the feeling that the intense statement possible in poetic form may be just that inevitable mode of stating the thing which is at once felt as an immense joy by the creator of the expression. (AB, pp. 162–63)

Revealing his frustration at the similarities he identified in scientific and literary method, he added,

> Now there must be some difference between this and scientific discovery. That consists of the presentation and rejection of hypotheses and the testing of these by thought or by experiment. The hypothesis in poetry consists in comparing statements of a thought judged to be competent and the rejection or acceptance of that thought and its presentation in forms found to be suitable.

Finally, he admitted some bewilderment, writing, "After all I have said, there lacks some definition of the scientific mind as opposed to or different from the purely poetic mind" (AB, p. 163).

Unlike Mitchell, Woodward believed that the differences between the scientific and literary process were most often external differences of subject matter and environment, while the internal dynamics required "the same type of mind" (AB, p. 156). Woodward was not at all uncomfortable focusing on the similarities between scientific and literary method, stressing the use of imagination and the ability to bring to mind a flood of images in scientific work.

In his book *Fact and Feeling: Baconian Science and the Nineteenth-Century Literary Imagination*, Jonathan Smith describes a nineteenth-century movement that "consciously conceived of scientific method as a valuably and inescapably imaginative process . . . agreement was virtually unanimous that science was far more imaginative than naive Baconianism would allow."[27] In Smith's one-culture approach, science and literature are complementary rather than mutually exclusive. Like writers of literature, scientists rely on inspiration, observation, selection, experimentation, and imagination in their search for truth. Not only is it impossible for them to

---

[27]Johnathan Smith, *Fact and Feeling: Baconian Science and the Nineteenth-Century Literary Imagination* (Madison: University of Wisconsin, 1994), p. 37.

collect all of the pertinent facts, but theory precedes observation. Moreover, theories do not arise out of facts but result from their imaginative interpretation. The very collection of facts follows the ideas that govern the research. Some antecedent, some purpose, or some question grounded upon an idea of the answer precedes the collection of significant facts. As systems of representation, both literature and science are shaped, in part, by ideological intentions and needs, aiming to contact and maintain or transform institutional practices and lived experience.

Ruth Hubbard, who had discussed reification as one of the major hazards of scientific language, has also argued that there is no such entity as "science," only the activities of scientists. Yet, it is usual in scientific language to delete the agent, removing the relevance of time and place and implying that the observation did not originate in a human observer but in the world. In this way the observation can be presented as though it were as real as nature itself.[28] In scientific writing the narrative of discovery is often omitted. Instead of revealing the process of invention, selection, and development, scientific writing focuses on outcome and results. The differences are not necessarily located in the opposition of scientific and literary methods, but in the rhetorical strategies scientists use to describe their work.

While Mitchell often compartmentalized his science as work and his literature as play, his commentary appears inconsistent. His strict division is not supported by his deductive method or the subsequent results. Rather than being separate, Mitchell's medical work—especially his medical writing and his treatment of women—and his novels are intimately related. Certainly, both his medical work and his literary efforts were ideologically driven. His idealization of "woman" and his assumptions about gender govern his medical work and writing alike. While pure induction may exist only in theory, Mitchell's preconceptions altered his powers of observation, eliminating the possibility of an inductive approach in treatment or narrative.

Describing a physician in *Dr. North and His Friends*, Mitchell wrote:

> He moves amid mystery. If he does not intellectually respect the complex riddles of soul, mind, and body, and their inter-

---

[28]Ruth Hubbard, *The Politics of Women's Biology* (New Brunswick: Rutgers University Press, 1990), p. 12.

> dependence, he is unfit for the higher seats in the temple of the god of medicine. . . . It is the power to reason from uncertain premises to conclusions as often unsure that makes the best physician. He practices an art not yet a science. It is based on many sciences. A man may know them all and be a less skilful healer than one who, knowing them less well, is master of the art to which they increasingly contribute.[29]

Mitchell always insisted that medicine, if not science, was an art, and in this insistence, at least, he accepted the dynamics of nineteenth-century medicine as an imaginative process.

On the title pages of his novels, Mitchell placed "M.D." after his name, and later, after receiving honorary degrees, he would place "LL.D. Harvard and Edinburgh" after the "M.D.," infusing his fiction with the authority of such recognition. Although Mitchell's placement of science beyond artifice and device created a distorted sense of scientific truth as opposed to the "fiction" of literature, he felt he could overcome this distinction between scientific fact and literary fiction. Viewing himself as a literary physician, he could make his fiction more true, powerful, and effective by integrating his medical work and knowledge of character into his literary writing. Mitchell's sharp distinction between his serious medical work and literary play broke down when he attempted to analyze scientific and literary methodology, revealing instead that writing was an extension of his medical work, and that the two had more in common than he was able or willing to acknowledge.

---

[29]Mitchell, *Dr. North and His Friends*, pp. 456–57.

Mary Putnam Jacobi's Letter of Protest (circa 1891)

Introduced and transcribed by Nancy Cervetti

An adventurous spirit and radical tendencies characterize the full and productive life of Mary Putnam Jacobi. Born in London of American parents in 1842, this brilliant and heroic nineteenth-century feminist physician combined considerable literary talent with a scientific career. She was only fifteen when her first publication appeared in the *Atlantic Monthly*. Many books and essays followed this auspicious beginning.

While reading Ruth Putnam's biography of Jacobi, one is struck by Jacobi's courage and strong will.[30] In 1863 she traveled alone into the swamps of Louisiana to nurse her brother Haven, a Union soldier suffering from malaria. In 1866, a few years after receiving her M.D. degree from the Female Medical College of Pennsylvania, Jacobi sailed for France seeking another degree. Initially rejected by the faculty of the Paris École de Médecine—in which no woman had ever set foot—Jacobi persisted. When, in 1868, she became the first woman to enter the historic amphitheater, the predicted riots did not occur. Jacobi's six years in Paris included the winter of the Prussian siege, which was marked by acute suffering and near starvation, and the months of the Communist occupation. When she graduated in 1871 she won a Bronze Medal for her thesis. She returned to New York with what Sir William Osler described as "a Paris medical degree and a training in scientific medicine unusual at that date even among men."[31]

Upon her return, Jacobi accepted the position of lecturer at the Woman's Medical College of the New York Infirmary for Women and Children, founded by Elizabeth Blackwell. From 1873 to 1889

[30]Ruth Putnam, *Life and Letters of Mary Putnam Jacobi* (New York: G.P. Putnam's Sons, 1925).
[31]The Women's Medical Association of New York City, *Mary Putnam Jacobi, M.D., A Pathfinder in Medicine* (New York: G.P. Putnam's Sons, 1925), p. xiv.

Jacobi held the position of Professor of Materia Medica and Therapeutics at the school. In 1872 she helped organize the Association for the Advancement of the Medical Education of Women. She served as the organization's president from 1874 to 1903. In 1876 she won Harvard's Boylston Prize for her essay "The Question of Rest for Women During Menstruation." Although this essay brought her admission to numerous medical societies, she was still denied membership to the national obstetrical society.

In 1894 Jacobi became actively involved in the women's suffrage movement. During the same period she worked to expand educational opportunities for African Americans and to protect Native Americans. In 1899 she published a book on educational theory entitled *Physiological Notes on Primary Education and the Study of Language.* She prepared more than one hundred papers for medical societies. Through her writing and her work she raised the standards of medical education for women and played a major role in dispelling the nineteenth-century myth that women were unfit for the medical profession.

In the following letter, published here in its entirety for the first time, Jacobi responds to S. Weir Mitchell's objections to women physicians as expressed in his novel *Characteristics.*[32] In the letter Jacobi reveals some of the difficulties she experienced as a woman doctor.

* * *

110 W 34th St.
June 3rd [no year]

Dr. S. Weir Mitchell,

I presume you could doubt, neither that I should be one of the interested readers of your charming series of sketches in the century; nor that I should protest against the remarks about "medical women" in their last issue. I know how much authority any expression of opinion upon your part carries: and I also know how few people there are who would note, that on certain subjects, the very circumstance that has invested your opinion with such just authority, really tends to disqualify you from forming an impartial judgment. I mean your prolonged

[32]S. Weir Mitchell, *Characteristics* (New York: The Century Co., 1900), pp. 251–52.

and profound study of nervous women, with all their incapacities, sophistries and essential feebleness. The recognition you so freely accord to the charm and cleverness and even brilliancy of many such women naturally cannot greatly change your estimate of their incapacity.

Do you not almost inevitably get into the habit of extending to the whole sex the estimate which you justly form of the multitudes of them which absorb your professional attention? As the gynecologists learn to doubt if any woman has a healthy uterus: and Emmet thinks it abnormal for menstruation to be unattended by pain? Do you not care to think of a certain capriciousness and especially the habit of craving and prizing the attentions of men as essential to "womanly charm," and that any habits of responsibility, or absorbing mental interests which may tend to diminish the relative importance to a woman of masculine attentions must detract from the feminine peculiarities which are traditionally the most delightful? You do not state in "characteristics" why medicine, above all other pursuits, should have this deteriorating effect upon feminine attractiveness. Nor suggest why occupations that are so necessarily stimulating to the personal sympathies which I believe to be the real basis of what is most legitimately feminine, should be capable of warping feminine character. These occupations, like any others which are serious and responsible, must tend to diminish coquetry; but how can they lessen the power of sympathy, the maternal instinct, which is at least as powerful and valuable an instinct as coquetry? Far be it from me to suggest that coquetry be banished from, or eradicated out of the world. But surely there will be women enough left for its development and exercise, even if the present handful of female physicians were multiplied ten or twenty fold.

Permit me to ask, when or where you have as yet met women physicians who have had "the same education as men"? I at least know of none such. To speak of no other disparity at present, the lack of positions in hospitals cannot but for many years establish the widest difference between them. And now sir, at the risk of manifesting an egotism which you may still further explain by the deteriorating effects of medicine, will you permit me to cite these facts of personal history, all relative to the question of recognition of ideas, even when a woman chance to have them.

A year before the appearance of your little book on Fat and Blood, I published in Seguin's *Archives* an essay on the cold pack and massage in anemia, embodying a good many precise researches, and containing many suggestions, which proved to be quite identical with many of yours. I had not, it is true, developed the theory of rest to the extent to which you subsequently carried it; but I had begun it, and in several cases had already carried it out. My essay appeared in book form about a year later, and a little after the publication of "Fat and Blood." It is not necessary to comment upon the extraordinary success of your little book, while mine, which was experimental as well as theoretical, has scarcely ever been heard of.

Again, in 1876 I developed a theory of rhythmic nutritive processes in connection with menstruation, which has been subsequently confirmed by such men as Hegar in Germany, and also by some English observers. But in America this is scarcely heard of, although certain phrases I formulated, as the "supplementary wave of nutrition," have been adopted without acknowledgment.

And once more: several years ago, and while gynecologists were still generally dominated by the teaching of Thomas and Emmet that the endometrium either did not exist, or was insignificant, or could not be treated, I published a rather elaborate paper asserting that all pelvic disorders necessarily started from the endometrium, that it and the cortex of the ovary formed a continuous germinal membrane, and that the lymph spaces originating on the endometrium were the channels of infection exciting all periuterine disease. That all intrauterine treatment was essentially surgical, and consisted in the destruction of the diseased membrane and permanent forms of disease. Today these very same ideas have suddenly rushed to the front: but because of the more powerful theoretical turn which Dr. Polk gave to the matter, he is credited with the entire priority and originality, and my earlier demonstration and argument is never mentioned. I do not, of course, quote these little matters as bearing upon that part of your indictment upon which you lay the most stress; but upon the other, which touches lightly on the question of female capacity.

Let me ask you once more: have you ever had an opportunity of watching a woman originally "charming" deteriorate under the influence of medicine? If not, how do you know that those whom you have met, medical and charmless, were

not always so, even before they had taken the fatal plunge? And have you compared the influence of millinery, dress making, traveling, journalism, authorship, business etc. etc., with that of medicine in this respect?

I would not venture to write so long a letter, were it not that I believe you will soon be at Newport and at leisure for idleness. I am sir,

Very truly yours
Mrs. Putnam Jacobi[33]

[33]S. Weir Mitchell Papers, College of Physicians, Philadelphia, Box 10, Series 4.4, Folder 15.

Memoir of Daniel Leonard Shaw, Jr., M.D. (1922–1997)

Robert H. Bradley, Jr.

The death of former President Daniel Leonard Shaw, Jr., on August 16, 1997, robbed the College of a devoted friend and generous benefactor. He had been a Fellow for forty-one years, during which he served the College in many positions of responsibility, leading to the presidency from 1990 to 1992.

Dr. Shaw guided the College at a time of transition. The adoption of the Austrian Report in 1989 required significant changes in organization and governance which became his responsibility. He was a "no-nonsense" leader who brought about change speedily and effectively. His dry and ready sense of humor facilitated his demands.

Financial pressure has been a constant threat throughout the College's life. Faced with the necessity of increasing income or cutting expenses, Dr. Shaw's keen business sense, developed during a long career at Wyeth-Ayerst Laboratories, told him that reducing College programs would be a self-defeating approach to the problem. Therefore, he chose the route of improving programs and increasing activities, believing that the involvement of more of the Fellowship in the College would bring additional support. This proved successful during his term, which was also noted for the adoption of the College's first business plan.

Dr. Shaw envisioned the College as a broad cultural institution, serving the medical profession and the community at large. He urged an increasing involvement with the business and educational communities. Accordingly, the Board of Advisors was enhanced by the addition of leaders from diverse fields. At the same time the College became a sponsor of the Vare Public School in South Philadelphia.

While Chairman of the Committee on Development, Dr. Shaw sought to inform the Fellowship of the many benefits accruing to both the donors and the recipients of planned deferred gifts. Setting a magnificent example, he and his wife Arlene set up a trust fund in favor of the College which, upon maturity, will constitute the largest single gift the College has ever received. This generosity has

enabled the College to establish the Katherine A. Shaw Public Services Division that includes the C. Everett Koop Community Information Center, the College Gallery, the Mütter Museum, and the College's medicinal plant garden. The division is named in honor of the Shaw's daughter, a librarian.

Dr. Shaw was born in 1922 in Clinton, Kentucky. He was close to a physician uncle who may have influenced his later decision to pursue a career in medicine. He received a B.S. degree from the University of Miami in 1942 and subsequently enlisted in the United States Navy. Experience as a laboratory technician encouraged him to enter Thomas Jefferson University Medical School, from which he graduated in 1948. After a year of internship at the Philadelphia Naval Hospital, Dr. Shaw became a resident at the United States Public Health Services Hospital in Hot Springs, Arkansas.

He returned to Philadelphia in 1950 and joined the staff at Wyeth Laboratories, where he became Director of Clinical Research in 1953. He progressed to Medical Director in 1962 and was promoted to Vice-President for Medical Affairs in 1971. Throughout his career he was involved with the development and distribution of new drugs. He retired at the age of sixty-four in 1984.

While in medical school, Daniel Shaw became attached to a Jefferson Hospital nurse, Arlene Dorn. They married in 1945 and raised three children: Katherine, Daniel, and Suzanne. Three grandchildren followed in due time. Dr. Shaw was very much a family man, interested in and close to his children. In turn, they remember his many hobbies and interests: stamps, music, and gardening. Daniel Shaw particularly loved sports and was an enthusiastic fan of the Phillies and the Eagles.

At the age of forty-four, Dr. Shaw suffered a massive myocardial infarction. A long convalescence followed, but he regained full activity and was able to return to sports. During his last decade, other problems made his life difficult. Macular degeneration destroyed his central vision. Cardiac arrythmias required frequent hospitalizations. He bore these infirmities with fortitude, grace, and few complaints. Ultimately, he did not die from cardiac disease, but from overwhelming sepsis secondary to the treatment of temporal arteritis with steroids.

Dr. Shaw was a devoted member of St. Luke's Lutheran Church in Devon. He will be recalled by his family, his friends, and his colleagues as a man who accomplished much and gave even more. His leadership and generosity have had a profound effect on the College of Physicians of Philadelphia, where his memory will long endure.

Notes on Contributors

Nancy Cervetti, Ph.D. is an Associate Professor of English and Director of Women's Studies at Avila College in Kansas City. She has published articles in *Women's Studies, The Victorian Newsletter,* and the *Journal of Modern Literature,* and her book, *Scenes of Reading,* was published in the spring of 1998. Her current research focuses on medical discourse, representation, and the female body.

Sarah B. Dine, M.A., M.Phil. was the Associate Editor for *The Diary of Elizabeth Drinker.* She has also worked on the papers of Charles Willson Peale and the Peale family for the Smithsonian and was Assistant Editor for volume 1 of *The Documentary History of the Supreme Court.*

Hugh E. Evans, M.D. is currently Professor of Preventive Medicine and Community Health at the University of Medicine and Dentistry of New Jersey. In addition to a prominent career in academic pediatrics, Dr. Evans has written and lectured nationally on the subject of Franklin D. Roosevelt's medical history.

Robert H. Ferrell is Professor Emeritus of History at Indiana University in Bloomington. He is the author of many books on international affairs and on the presidency, including *Ill-Advised: Presidential Health and Public Trust, The Strange Death of President Harding,* and most recently *The Dying President: Franklin D. Roosevelt, 1944–1945.*

John K. Lattimer, M.D. has been Chairman of the Department of Urology of the College of Physicians and Surgeons of Columbia University, President of the American Urological Association, President of the International Society of Urology, and President of the American Association of Genitourinary Surgeons. He recently published *Kennedy and Lincoln: Medical and Ballistic Comparisons of Their Assassinations.*

Marc S. Micozzi, M.D., Ph.D. has been the Executive Director of the College of Physicians of Philadelphia and Adjunct Professor in

the Department of Rehabilitation Medicine at the University of Pennsylvania since 1995. He was previously Director of the National Museum of Health and Medicine and Distinguished Scientist with the American Registry of Pathology in Washington, DC. Dr. Micozzi has written and lectured extensively about the health of Presidents Lincoln and Kennedy as well as about nutrition, cancer prevention, medical anthropology, and complementary therapies.

Bert E. Park, M.D. is a practicing neurological surgeon and adjunct professor of history who has written numerous articles and two books on the illnesses of world leaders and historical figures: *The Impact of World Leaders* and *Ailing, Aging, and Addicted: Studies of Compromised Leadership*. He also served on the Editorial Advisory Committee for the Papers of Woodrow Wilson at Princeton University.

Senator Arlen Specter received his undergraduate degree from the University of Pennsylvania in 1951 and his law degree from Yale Law School in 1956 after serving in the Air Force Office of Special Investigations for two years. He played an important role as part of the Warren Commission staff investigating the assassination of President Kennedy. He currently chairs the Senate Veteran's Affairs Committee and the Appropriations Subcommittee on Labor, Health and Human Services, and Education, and is a member of the Judiciary and Governmental Affairs Committees.

College of Physicians of Philadelphia 1997

Marc S. Micozzi, M.D., Ph.D., *Executive Director*

Thomas A. Horrocks, M.A., M.L.S., *Director of the Francis Clark Wood Institute for the History of Medicine and Director of the Historical Division of the Library*

Andrea L. Kenyon, A.M.L.S., *Director of the Katherine A. Shaw Division of Public Services and Programs*

Marjorie Smink, M.S., *Associate Director of the Katherine A. Shaw Division of Public Services and Programs*

Gretchen Worden, *Director of the Mütter Museum*

Antonia Oberthaler, *Director of the Executive Office and Programs*

Dick Levinson, *Director of Public Affairs*

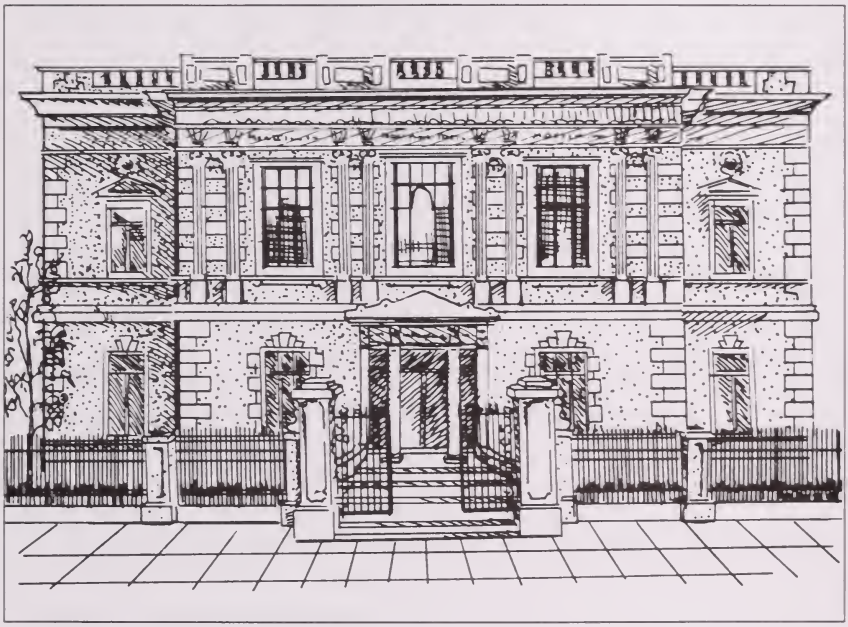
Benjamin R. Pierce, *Chief Operating Officer*

Mae O'Brien, *Director of Development*

Raymond O'Donnell, *Controller*

Deborah Julie Franklin, M.D., Ph.D., *Interim Editor, Transactions and Studies*

TRANSACTIONS & STUDIES



of the

COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XX December 1998

Copyright © 1999 by the College of Physicians of Philadelphia

TRANSACTIONS & STUDIES OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XX December 1998

Editorial v
DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1998 1
ALFRED P. FISHMAN

Report of the Katherine A. Shaw Public Services Division 6

Report of the Library 13

Selected Reports from Fellows of the Wood Institute for the History of Medicine 20

Conference Notes: Hippocrates and Modern Medicine

Keynote Speech 41
ALFRED P. FISHMAN

Feature Articles

"A deep fund of hatred and resentment": Clinical Encounters in Eighteenth-Century England 51
LYNDA STEPHENSON PAYNE

"The foul altar of a dissecting table": Anatomy, Sex, and Sensationalist Fiction in Mid-Nineteenth-Century America 65
MICHAEL SAPPOL

From the Historical Collections of the Library

Charges of unethical conduct made by the Camden County Medical Society against Samuel D. Gross, M.D. and Joseph Pancoast, M.D.
Introduced and transcribed by 98
HENRY H. SHERK AND KATHERINE S. SIMONS

Memoirs

Mark W. Allam (1909–1998) 115
ALAN M. KELLY

Mark W. Allam (1909–1998) 117
KATHERINE R. STURGIS

Emily Hartshorne Mudd (1898–1998) 119
LUIGI MASTROIANNI

Notes on Contributors 123

Editorial

The material in volume XX of *Transactions and Studies* has been a delight to work with. Scholars Nancy Cervetti, Laura Otis, and Jennifer Tuttle continued their reevaluation of the prominent College Fellow, S. Weir Mitchell, M.D. This scholarship, generated in part by the College's purchase of the S. Weir Mitchell Papers, is having an interdisciplinary impact among students of history, literature, women's studies, and medical history. Volume XX also reflects the College and the Wood Institute for the History of Medicine's commitment to history and the humanities, in this case the history of medical ethics. The conference, "Hippocrates and Modern Medicine," co-sponsored by the College and the Wood Institute, produced a significant body of scholarly work which will be available in book form by the spring of 1999. As part of this conference, College President Alfred P. Fishman, M.D. reviewed the history of Hippocrates' influence from the times when the Hippocratic corpus was the basis of medical education and practice through the late twentieth century, when Hippocrates' name continues to motivate and inspire people seeking to safeguard the ethics of contemporary medical care.

Lynda Payne, R.N., Ph.D. and Michael Sappol, Ph.D approach medical ethics from a historical perspective, with fascinating results. Payne reviews an eighteenth-century case of medical and surgical malpractice and reveals the charged social interactions that shaped the definition of medical ethics later popularized by John Gregory and Thomas Percival. Sappol uses the colorful "yellow novels" of the early nineteenth-century to probe some of the serious charges aimed at professional medicine by an often disaffected public. Despite the exceedingly harsh criticism of nineteenth-century physicians, and in particular Philadelphia's physicians, in John Hovey Robinson's *Marietta* and George Lippard's *Quaker City*, Sappol shows us how influential the physician's anatomical and physiological views had become. Henry Sherk, M.D. and Katherine Simons, M.A. add to volume XX's focus on the history of medical ethics by unearthing a remarkable exchange of letters between members of the Camden County Medical

Society and two very well-known Philadelphia physicians, Samuel D. Gross, M.D. (1805–1884) and Joseph Pancoast, M.D. (1805–1882). This correspondence reminds us, again, how central professional etiquette was to the definition of medical ethics during the nineteenth century and underscores the need for an initiative in the history of medical ethics if we are to gain a greater understanding of how these preoccupations persist but also how they became transformed into the field of bioethics we see flourishing today.

As a historian, I was struck by the memoirs Alan Kelly, V.M.D., Katherine Sturgis, M.D., and Luigi Mastroianni, M.D. have written. These are not just testaments to former colleagues and supporters of the College. The lives of Mark W. Allam and Emily Hartshorne Mudd reflect developments in twentieth-century medicine that had national and even global impact.

I can only hope that reading this material will be as enjoyable as readying it for publication has been. I would like to thank the College Board and the College Staff for the opportunity as well as the support and the assistance they have provided.

DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1998

Alfred P. Fishman, M.D.

It is customary for the departing President to present the Council with a brief overview of his term of office. My term was somewhat longer than usual because of my predecessor's terminal illness. Fortunately, I was able to benefit from Fred Murtagh's vision and advice during his final year in office as I gradually took over the reins.

A great deal has happened during the past three years. Strong leadership by the President-elect, Charles T. Lee, Jr., coupled with the energetic activities of the various committees, e.g. Admissions, Programs, Administration, Development, Finance, and the new Library Advisory Committee, have imbued the College with renewed vitality and are opening exciting frontiers. Much of this energy has been catalyzed by our new Executive Director. There is much to report, but instead of encumbering the text with details of progress and innovations, I have chosen to describe only a few examples of recent advances, reserving others for mention in the appended table.

As this report goes to press, a proposal for reorganizing the governance of the College is being readied for final approval by the Council. The reorganization includes such important changes as the replacement of the Council by a Board of Trustees, a new mechanism for nominating officers of the College, and the inclusion of distinguished non-physicians as full-fledged members of the Board. This restructuring requires changes in the by-laws, as documented elsewhere. The College is indebted to Dr. William Kissick, Dr. Charles T. Lee, Jr., and members of the Task Force on Board and Membership Development for this valuable modernization of our governance.

The call at the start of my term was for program development, but a meaningful response called for additional resources. The Council, preoccupied with the need for improved financial stability, had to face the challenge of mobilizing additional funds for innovative programs. It is gratifying to be able to report that the financial state

of the College has improved greatly during the past two years so that assets have kept pace with programmatic needs. Moreover, the prospect of further improvement is good as sources of funding continue to materialize and as a restructured Development Office moves into place.

The College's commitment to specific "themes" has shaped our programmatic endeavors. The Library, especially its historical collections, has been an important theme. We have realigned our goals towards preserving and enriching the historical collections even though this commitment could only be satisfied at the expense of current subscriptions. As Director of the Library, Marjorie Smink is currently guiding this operation. Connected to this reaffirmation of the historical collections as a capstone of the College has been the ongoing reappraisal of the structure and function of the Wood Institute for the History of Medicine and the prospect of developing a historical collection at the College devoted to medical ethics. The Council regrets that Thomas Horrocks has left the College for a new post at the Countway Library in Boston and will not be here to help steer these new excursions.

Three other themes have not only been launched, but have prospered far beyond our initial expectations: Public Health and Preventive Medicine, Medical Ethics, and Arts Medicine. Each of these themes supplements rather than duplicates existing programs at the medical schools and other health institutions in Philadelphia. Thematic programs and greater opportunities for involvement in College activities are thought to be responsible, at least in part, for the dramatic increase in membership applications that the College has experienced in the last year. Skillful leadership and judicious review of credentials by the Admissions Committee, under Dr. Howard Snyder with the able assistance of the Membership Coordinator, Doris Werner, have ensured that physicians who become Fellows add to the honor and distinction of the College.

In addition to financial stability and new programs, attention was directed towards the organization of the College so that its governance might be in keeping with its aspirations for the future. At its next meeting, the Council is scheduled to act on the plans for restructuring as documented elsewhere.

A major initiative of the College, under the new Division of Public Services, is the C. Everett Koop Community Health Information Center (CHIC). Both Dr. Micozzi and Andrea Kenyon were instrumental in launching and developing this outreach program. It has served its original purpose of helping local community members

and visitors to the College obtain information about health and disease, but it has quickly evolved into a national model for providing physician-based health information to the community. The United States Centers for Disease Control in Atlanta have expressed interest and support for CHIC as a model to be replicated in other communities. Two more traditional activities under the purview of the Division of Public Services are the renowned Mütter Museum, directed by Gretchen Worden, and the Medicinal Plant Garden sustained by the Women's Committee of the College. Both have become local landmarks and national hallmarks of the College. The space allotted for this report is too limited to do justice to either of these noteworthy aspects of the College.

One outstanding triumph for the College during the past two years was the exhibition and program "When the President is the Patient." This exhibition documented and illustrated the dramatic histories of presidential illness and disability in the White House, beginning with George Washington and continuing through Wilson, Roosevelt, and others in the modern era. The exhibition, along with a related lecture series and a Forum on Presidential Disability and the Twenty-fifth Amendment, have paved the way for the College to develop an advocacy position concerning the need for impartial monitoring of the President's health and for arranging orderly transition in the event of presidential disability. Plans are under way to perpetuate the exhibit and to replicate it elsewhere by producing a CD-ROM, by reinstalling a permanent exhibit at the College, and by collaborating with other organizations. As Director of Public Affairs, Dick Levinson orchestrated the local, national, and international attention this exhibition brought to the College.

The standard of excellence of activities outlined above was matched by a remarkable series of evening lectures by distinguished physicians and professionals in fields related to medicine and health. Antonia Oberthaler deserves great credit for conducting these programs. One innovative program, deserving special mention, was the creation and implementation of the Jonathan E. Rhoads Commemorative Lecture, a collaborative effort between the College, the American Philosophical Society, and the Department of Surgery of the University of Pennsylvania. Dr. Rhoads has played a creative role in each of these organizations and a cooperative venture is a fitting recognition of his contributions to each of them. The success of this initiative has raised the prospect of future collaborative efforts. The College, for example, is exploring partnerships with the Academy of Natural Sciences, the American Philosophical Society, and other

Philadelphia institutions as part of the national celebration of the Lewis and Clark Expedition scheduled for 2003.

This text and the table on the following page provide a brief overview of the many and diverse activities of the College over the past two to three years. Implementation of these activities has drawn heavily on the time, energy, and efforts of many College Fellows. Without a dedicated Executive Director and staff, much of what has materialized would not have happened. Nor is the tempo likely to slow. As I write, new initiatives are being planned or are under way to ensure a stable future for the College and to enable it to live up to its full potential in the years ahead. I am confident that the list of accomplishments will grow under the leadership of President-elect Dr. Charles T. Lee, Jr. and his designated successor, Dr. Allen Myers.

Table of Activities and Initiatives, 1996–1998

Support for Established Policies and Programs

- Increase financial stability
- Excellent lecture series
- Activities of the Women's Committee
- Mütter Museum
- Improve physical plant
- Modernize electronic systems

New or Revitalized Initiatives

- Increase membership
- Engage members in College activities
- Identification and cultivation of College themes: Medical History, Public Health, Arts Medicine, Ethics
- Modernize the governance of the College
- Community Outreach Programs: Koop Community Health Information Center
- Exhibition: "When the President is the Patient"
- Sponsor joint activities with other scholarly and scientific societies in Philadelphia

Immediate Priorities and Prospects

- New leadership of the Wood Institute for the History of Medicine
- Reorganization of the Development Office
- Increased attention to the College's historical collections
- More effective use of the Library
- Development of a Center for the History of Medical Ethics
- Implementation of new governance (Board of Trustees)
- Increasing federal financial support for programs

Katherine A. Shaw Division of Public Services and Programs Annual Report July 1997–June 1998

The Katherine A. Shaw Public Services and Programs includes the C. Everett Koop Community Health Information Center (CHIC), College Gallery, the Mütter Museum, the Reception Desk and Gift Store, and the Special Events and Facilities Rental program.

The C. Everett Koop Community Health Information Center (CHIC)

CHIC encourages the public to take a more active role in the management of their health by providing ready access to a broad spectrum of current information on medicine, health maintenance, disease prevention, and health care services. The culturally diverse collection of materials includes books, journals, newsletters, videos, computer databases, CD-ROM products, Internet access, and pamphlets for adults, children, and adolescents in both English and Spanish. CHIC's hours are the same as the hours of the College Gallery and Mütter Museum: Tuesday through Saturday from 10 A.M. to 4 P.M. Four thousand nine hundred and ninety-eight (4,998) individuals visited CHIC in FY 1998. Fifty-three subscribers paid an annual membership fee of twenty dollars to borrow materials from the CHIC collection.

The College continued to explore CHIC's role in community-based provision of health information. A pilot project, funded in 1997 by the Health Resources and Services Administration (HRSA) of the U.S. Public Health Service, assisted the College in identifying the information needs of health professionals and patients associated with two federally funded health centers in Philadelphia: Fairmount and Maria de los Santos. The College staff are working with

health care workers at these facilities to identify quality consumer health information pamphlets and videos addressing obstetrical and gynecological topics in English and Spanish. CHIC staff are expanding their knowledge of the barriers to health information and are identifying ways to increase access and utilization of health information resources by under-served populations.

The Centers for Disease Control and Prevention are currently in the process of evaluating the effectiveness of CHIC as a national model for the provision of physician-based health information. The evaluation will assess (1) effectiveness of CHIC's products and services from the user's perspective; (2) usage of CHIC's products and services and barriers to their use; (3) the effectiveness of collaborative arrangements with nonprofit organizations, corporations, libraries, government agencies, and voluntary health agencies; (4) the quality of available resources in terms of currency, accuracy, readability, organization, and cultural diversity. The study will serve two purposes. It will help the College's CHIC improve its services and, thus, its prospects for long-term, stable funding. At the same time, documentation of the development, operation, and effectiveness of CHIC will allow the CDC and others to use CHIC as a national prototype for similar physician-based health information centers in other locations around the nation.

The College continued its efforts to integrate the information resources of CHIC with the educational opportunities offered through the Museum and Gallery. CHIC staff will develop information fact sheets on diseases discussed in the College Gallery's next exhibition: "Emerging Infectious Disease: Ancient Scourge and Modern Menace." These fact sheets, which will be available in the Gallery, will provide additional information on health issues raised by the Gallery exhibit, including references to books, pamphlets, articles, and Internet sites. Signs are also positioned throughout the Museum and Gallery encouraging visitors to stop by CHIC for further information on topics discussed in the exhibitions.

Mütter Museum and College Gallery

Visitors and Income

The total number of visitors for FY 1997 was 20,142, compared with 24,036 for the previous year. Part of this drop was caused by the change in hours that took place in July 1997. Because weekends

continued to draw the highest attendance, Tuesday through Saturday, 10 A.M. to 4 P.M., were selected as the most effective hours when a switch was made from a six-day-a-week schedule to a five-day-a-week schedule in July of 1997. Only 2,928 people visited the Museum and Gallery on Mondays during FY 1997. Reasons for the loss of additional visitors have not been fully determined, but may be related to changes in admission fees. Revenues from admissions subsequently dropped to $96,282 for FY 1997 from an all-time high of $112,371 the previous year.

Reception Desk and Gift Store

Museum and Gallery admission are now collected at the Reception Desk. The College continues to operate a small gift store in the Reception area operated by College Receptionist, Dori Panzer. College postcards, College calendars, and College publications as well as health-related novelties are sold through the Gift Store.

Museum/Gallery Tours

As Co-Chairpersons of the College Guide Program, Mrs. Robert Booth and Mrs. John Brobeck continued to provide the College with an active museum guide program. Museum guides include Mrs. Emily Baxter, Mrs. E. Howard Bedrossian, Mrs. Robert Booth, Mrs. John Brobeck, Mrs. James B. Carson, Mrs. Kenneth Cundy, Mrs. Marshall Guthrie, Mrs. William G. Minster, Mrs. Edward Schulman, Dr. Joseph M. Winston, and Mrs. Jean Conroy. Dori Panzer, College Receptionist, has been responsible for coordinating tours with the guides. Mrs. Bedrossian and Mrs. Brobeck are sharing the "role" of Tour Guide liaison to the Womens' Committee and have begun to focus their attention on recruiting more tour volunteers. In FY 1998, 330 groups visited, with an average group size of twenty to twenty-five people.

The project of labeling all portraits on display in the College's public and private spaces was completed during the spring of 1998 under the direction of Marjorie Smink, Director of the Library. Label information includes the name of the subject, their date of birth and date of death, positions the subject held at the College, the artist's name, the donor's name, the date of donation, and the item's Portrait Catalog number. Summary descriptions of each portrait are available on information sheets in each room to allow self-guided

tours of the portrait collections. Several volunteers are receiving special training so that they will be able to give portrait tours.

Mütter Museum

Special Projects, Lectures, and Exhibits

On September 9, 1997, the Director of the Mütter Museum, Gretchen Worden, presented a comprehensive plan for the reinstallation of the museum's permanent collections, based largely on the design proposed as part of the museum's renovation in 1984–86, but incorporating changes reflecting the college's new programmatic priorities.

The first phase of this plan, an exhibition on "The Museum in Medical Education," was approved for implementation beginning in the spring of 1997. The purpose of the exhibition is to introduce modern audiences to the role that medical museums played in the training of physicians in the past. It also explains how specimens and models are prepared. The history of the Mütter Museum as part of the College is described. The exhibition will feature the Hyrtl skull collection as representative of the College's major collecting activity during the late nineteenth century.

The exhibit was designed and installed by Lori Hamilton, an intern from the University of the Arts Graduate Program in Museum Exhibition and Design, with funding from the Groff Family Memorial Trust. The Director of the Mütter Museum, Gretchen Worden, generated a script outline. Erin McCleary, a doctoral candidate in the Department of the History and Sociology of Science of the University of Pennsylvania, did the necessary research for the exhibition's text.

Lectures

Joseph H. Davis, M.D. delivered the ninety-fourth annual Mütter Lecture on December 2, 1997. His talk, entitled "Why Did He Die? He Wasn't Supposed To!" dealt with the phenomenon of sudden and unexpected death outside a hospital and how medical examiners can detect patterns of disease and pathology to explain these mysterious occurrences. College Fellow Halbert E. Fillinger, Jr., M.D. provided a formal commentary after the lecture. Dr. Davis served

for almost forty years in the Medical Examiner's Office of Dade County, Florida. During that time, he supervised the evolution of the department into one of the most modern facilities of its kind, inaugurated educational and research programs which attracted scholars and students worldwide, developed a Forensic Pathology residency program, and authored or co-authored over a hundred papers and book chapters.

Lectures given by the Director of the Museum, Gretchen Worden, included "Three Centuries of Philadelphia Obstetrics," Grand Rounds for the Obstetrical Department at Reading Hospital, an informal presentation to the University of the Arts Museum Design Class on the Mütter Museum, and a brief address to the University of Pennsylvania Endowed Chair lunch on "Famous Philadelphia Physicians in the Woodlands Cemetery."

Loans

The Museum lent a substantial amount of material to the Michener Museum in Doylestown for its exhibition celebrating the seventy-fifth anniversary of the Doylestown Hospital. The loan included furnishings and instruments from a doctor's office during the 1920s and examples of medical illustration from drawings to x-ray images.

Accessions

Objects donated to the museum during FY 1998 included assorted diagnostic instruments from the Philadelphia Electric Company; a Baumanometer, ophthalmoscopes, a doctor's bag and other items from Dr. Sidney Krasnoff; the bag of Dr. Frank Sharpe from his daughter Lilla Sharpe; a Phaco-fragmenter from Dr. Alban Smith; and a copy of a portrait of Dr. Howard H. Steel, made by the artist, Will Barnet, and presented by Dr. Steel. Once again, a shortage of collections management staff meant that none of the donations were processed or accessioned.

Mütter Associates

On February 3, 1998, the Mütter Associates hosted a buffet dinner and tour of the museum for the Associates and other Friends of the Museum. Mütter Associates Chairman, John M. Templeton Jr., M.D. welcomed those attending, and described the needs of the museum and the Associates' support of Museum programs and activities. Nine

Fellows and their spouses attended, as did three College staff members. Dr. Templeton has set an example for other Fellows by directly supporting the museum with a pledge of $25,000 a year for three years, to be matched by $10,000 each year from other sources. These funds will provide a salary for a Collections Manager.

College Gallery

The College Gallery's next exhibition, "Emerging Infectious Diseases: Ancient Scourge and Modern Menace," is scheduled to open in October 1998. Andrea Kenyon, Director of Public Services, has been coordinating the project and serving as principal script writer, with assistance from Gretchen Worden, Director of the Museum and Marc S. Micozzi, M.D., Ph.D., College Executive Director. Research Assistant Bruce Scherer was hired to identify historical images for inclusion in the exhibit. The exhibit is being designed by Kim Tieger, who helped mount the Gallery's previous exhibition, "When the President is the Patient." An advisory team including Bennett Lorber, M.D., Sheila Moriber Katz, M.D., Stephen J. Gluckman, M.D., Maythew Levison, M.D., Alexandra Levitt, M.D., Rob Roy MacGregor, M.D., Neal Nathanson, M.D., Sindy M. Paul, M.D., and Walter Tsou, M.D. helped the College staff focus the exhibition on two main themes: the globalization of infectious disease because of immigration, travel, and trade and the constant evolution of disease-causing microbes as they adapt to new therapies and medicines. The exhibition will encourage a personal understanding of infectious disease processes by recreating a typical American kitchen, thereby revealing hidden dangers from contamination. The exhibition will also highlight three major infectious disease outbreaks in Philadelphia's history—the yellow fever epidemic of 1793, the influenza pandemic of 1918–1919, and the discovery of Legionnaire's disease in 1976. The yellow fever epidemic of 1793 was the subject of a Wood Institute conference in 1993. Papers presented at that conference are available through the College gift store as part of J. Worth Estes and Billy G. Smith's edited volume, *A Melancholy Scene of Devastation: The Public Responses to the 1793 Yellow Fever Epidemic.*

Museum artifacts on display will include syphilitic and tubercular bone specimens, wax models showing smallpox, vaccination instruments, a microscope, as well as Benjamin Rush's medicine chest and bloodletting instruments. Library contributions will include rare

books and manuscripts addressing various infectious diseases, including bubonic plague.

College Calendar

The College is again producing a calendar of images from the Museum and Library collections, photographed by Jack Ramsdale. The theme for 1999 is "The Art of Medicine." Bookplates and medical illustrations from the library and models and instruments from the museum are used to reveal the complex skills that went into crafting functional yet aesthetically pleasing tools and teaching aids. Stinehour Press was selected as the printer, because they had previously produced the Mütter calendars. The calendar will be sold to bookstores, to the Calendar Club, and at a discount to the Fellows. A full-color flyer showing all of the images was printed in order to publicize the calendar to stores, Fellows, and other individuals. The calendar is available through the College Gift Store.

Library
Annual Report
July 1, 1997–June 30, 1998

In January 1997, the Library Task Force under the chairmanship of Robert Reinecke, M.D. held an Open Forum on issues relating to the Library. Fellows of the College voted on the proposed policy recommendations of the task force. The following recommendations were accepted:

1. That the College continue to acquire contemporary materials in the history of medicine, medical ethics, arts-medicine, and public health and preventive medicine.
2. That the College enhance and preserve its historical library.
3. That the library's general medical reference materials be substantially reduced, currently and on an ongoing basis, to allow investment of staff, space, and material resources towards strategic directions that reflect the College's unique role and responsibilities.
4. That the College continue to investigate the capabilities of medical information technologies and electronic outreach and the opportunities they afford the College.
5. That there be an appropriately constituted permanent library advisory committee to oversee implementation of adopted recommendations and to report, through standing committees, to the Council.

As a result of this vote, the College Library, operating out of the Ashhurst Reading Room, began concentrating on the historical collections (pre-1966) as of July 1, 1997. Support services (Technical Services and Interlibrary Loan/Document Delivery) came under the supervision of the Director of the Library. The modern library's operations (post-1965), including the consumer health collection, came under the Director of Public Services, and were reorganized through the Koop Community Health Information Center on the first floor of the building.

Staff

In November 1997, Thomas Horrocks, Director of the Library, became the Curator of Rare Books and Manuscripts at the Countway Library, Harvard Medical School. Marjorie Smink, former Associate Director of Public Services, was promoted to the position of Director of the Library. Historical Reference Librarian Jeffrey Anderson accepted a position at the University of Pennsylvania and was replaced by Christopher Stanwood, a recent graduate of Rutgers University's Masters program in Public History.

Director of the Library:	Marjorie Smink (since 11/97) Thomas Horrocks (through 10/97)
Curator of Archives and Manuscripts:	Charles Greifenstein
Historical Reference Librarian:	Christopher Stanwood (since 2/98) Jeffrey Anderson (7/97–11/97)
Administrative Assistant:	Josefa Sereda
Coordinator for Technical Services:	Joan McKenzie
Coordinator for Document Delivery:	Tonya Tate
Telecommunications Operator/Serials Assistant:	Tamara Viney
Document Delivery Assistant:	Marita Williams
Document Delivery Services Clerk:	Sharon Lutes
Document Delivery Clerk:	Pat Filemyr

Reference Services

The Reference Desk in the Ashhurst Reading Room was open Tuesday through Friday, from 10 A.M. to 4 P.M., by appointment. Patrons included academic historians, general academic scholars, writers, genealogists, students—both undergraduate and graduate—physicians, Fellows, lawyers, librarians, and publishers. Eighty-four percent of

the patrons came from the mid-Atlantic region, four percent from foreign countries. Seven hundred and forty-two patron visits were recorded for the year. Six hundred and ninety-six reference questions came from phone calls, letters, e-mail messages, as well as patrons in the library. Over 5,000 items were retrieved from the stacks to serve these patrons. Thirteen percent of the accessed collections were from the Library's Cage, where rare books, archives, and manuscripts are stored. Fifteen tours and displays of rare books and manuscripts were provided by the reference staff. Two hundred and twenty-three finding aids for manuscripts and archives (181 individuals, forty-two organizations and subjects) were mounted onto the College's web site.

Accessions

Total number of archive and manuscript collections accessioned:

Five manuscript collections were received as gifts from outside the College, including

- correspondence of William W. Keen (1837–1932) from W.W. Keen Butcher (grandson)
- papers of Waldo Emerson Nelson, M.D. (1898–1997) from Jane Nelson Beatty (daughter)
- 4.4 linear feet of archival collections were accessioned from College staff files.

Acquisitions

Total volumes of books (purchased and donated): 95

Cataloging

Total volumes cataloged (new and retrospective) on OCLC: 91
Total number of collections cataloged on RLIN: 0

Interlibrary Loan/Document Delivery

The College of Physicians has a rich collection of books and journals exceeding 350,000 volumes, 250,000 of which are part of the historical collection (pre-1966). The institution is considered a net-lender in the interlibrary loan process.

Borrowing from other libraries:

Total number of books and journal articles obtained for Fellows and staff: 251

Lending to others:

Total number of journal articles provided to Fellows, corporations, and libraries: 15,855

Total number of books and pamphlets loaned to individuals, corporations, and libraries: 1,067

Samuel Lewis Circle

The Samuel Lewis Circle, established in 1991, consists of Fellows and friends of the College library who are dedicated to enlarging and preserving its historical collections. Members of the circle donate funds to purchase books and manuscripts and support preservation measures that exceed the library's budget. The seventh anniversary of the Circle was celebrated with a dinner in the Hutchinson Alcove on January 13, 1998 and was attended by 11 Samuel Lewis Circle members, 3 College staff members, and 5 guests. Marc Micozzi, M.D., Ph.D., Executive Director, welcomed everyone and introduced the Chair of the Lewis Circle, Eugene Flamm, M.D. and the exhibit "Going, Going, Gone?: Preserving the Historical Collections of the Library of the College of Physicians of Philadelphia" prepared by Charles Greifenstein, M.A., M.S., Curator of Archives and Manuscripts. Guest speaker Dale Smith, Ph.D., Professor of the History of Medicine at the Uniformed Services University of the Armed Forces in Bethesda, MD challenged the audience with a talk about the importance of teaching the history of medicine to medical students. There were nineteen members of the Lewis Circle in 1997–98.

Francis C. Wood Institute for the History of Medicine Combined Annual Report July 1, 1996–June 30, 1998

Director: Thomas Horrocks (through 10/97)

Scholar-in-Residence: Michael Sappol (9/97–8/98)

Michael Sappol, Ph.D. was the Scholar-in-Residence for the 1997–98 academic year. His research on sources in the College's historical collection became the basis of a series of inter-linked essays:

"Dissecting the Body Electric: Anatomical Embodiment and the Production of Social Identity in Nineteenth Century America." His studies focused on antebellum medical literature, particularly the response of antebellum Protestant theologians, evangelists, and popular writers on health. He explored themes of literary romanticism and sensationalism in order to see how these writers opposed or appropriated contemporary anatomical and physiological discourse to promote their own understanding of the spirit-matter dichotomy.

Resident Research Fellow:

The Wood Institute offered resident research fellowships in the form of short-term grants of up to $1,000. These were available to scholars pursuing projects that require use of the Library's historical collection or the Mütter Museum. Nine fellowships were awarded in FY 97. Recipients of these grants and their research topics are listed below:

Sharon A. Fish, R.N., M.S.N. (Ph.D. candidate, University of Rochester):
"Therapeutic Touch: Occult Healing in Nursing."

Brad D. Hume (Ph.D. candidate, Indiana University):
"The Varied, the Average, and the Type: Fracturing and Factoring the Human Subject in the Nineteenth Century."

Carla C. Keirns (Ph.D. candidate, University of Pennsylvania):
"Short of Breath: Asthma in American History."

Scott C. Martin, Ph.D. (Bowling Green State University):
"Medical Opinion and Gender in the Early Nineteenth-Century Temperance Movement."

Laura C. Otis, Ph.D. (University of Chicago):
"The Cell and The Self."

Heather Munro Prescott, Ph.D. (Central Connecticut State University):
"Student Bodies: A History of College and University Health."

Steven J. Holmes, Ph.D. (Harvard University):
"The History of Stuttering in Nineteenth-Century America."

Jennifer S. Tuttle, Ph.D. (University of California, San Diego):
"Empire of Sickness: Literary Professionals and Medical Discourse in the Age of American Nervousness, 1869–1911."

Karol K. Weaver (Ph.D. candidate, Pennsylvania State University):

"History of Disease in Eighteenth-Century Saint Domingue."

Seminar Series

Fall 1997

Oct. 30: Laura Otis, Ph.D. (University of Chicago):

"Resisting Rattlesnakes: S. Weir Mitchell's Concept of Identity."

Nov. 6: Neil McDowell, M.A. (University of Pennsylvania):

"Pestilence in Print: Sixteenth-Century German Plague Literature."

Nov. 13: Edward C. Leonard, Jr., M.D. (Fellow, College of Physicians of Philadelphia):

"S. Elizabeth Winter, M.D. (1869–1938): Pioneer Psychiatric Entrepreneur."

Nov. 20: Hugh E. Evans, M.D. (University of Medicine & Dentistry of New Jersey):

"The Medical History of President Franklin D. Roosevelt."

Commentator: Robert H. Ferrell (University of Indiana, Bloomington)

Dec. 4: Carla Gerona, Ph.D. (Johns Hopkins University):

"The Healing Dreams of Benjamin Banneker."

Spring 1998

Feb. 19: James Trent, Ph.D. (Southern Illinois University at Edwardsville):

"'Who Shall Say Who Is a Useful Person': Abraham Myerson and the Psychiatric Opposition to the Eugenics Movement."

Feb. 26: Nancy Siraisi, Ph.D. (Hunter College and Graduate Center, CUNY):

"In Search of the Origins of Medicine: Egyptian Wisdom and Some Sixteenth Century Physicians."

Mar. 5: Sue Wells, Ph.D. (Temple University):

"Legible Bodies: Nineteenth-Century Women Physicians and the Rhetoric of Dissection."

Apr. 9: David Harley Serlin (Ph.D. candidate, New York University):

"Reconstructing the Hiroshima Maidens: Cosmetic Surgery during the Cold War."

Apr. 16: Barbara Will, Ph.D. (Dartmouth College):

"Neuresthenia as a Cultural Phenomenon in America from 1880–1915."

Apr. 23: Luise White, Ph.D. (Emory University):

" 'Bandages on your mouth': Experience and Narrative in the History of Colonial Medicine in Eastern Africa."

Apr. 30: Andrea Balis, M.A. (Hunter College, CUNY):

"The Popular Reception of Sulfa Drugs."

Wood Institute for the History of Medicine: Fellows' Reports

Laura Otis

Identity and Pathology in S. Weir Mitchell's Early Scientific Writing

While S. Weir Mitchell's career in medicine and novel-writing offers fascinating opportunities for studying how literature and science spin out the same ideas, most interdisciplinary scholars have concentrated on Mitchell's popular scientific writings, describing his Rest Cure for nervous patients. Physiologist, neurologist, and fiction writer, S. Weir Mitchell (1829–1914) performed pioneering studies of nerve injuries in Civil War veterans, developed a treatment for neurasthenia that was adopted internationally, wrote many successful novels, and discovered how rattlesnake venom affects the body. As a scholar of literature and neuroscience, I quickly became intrigued by Mitchell's notions of selfhood and identity and wondered to what degree his early scientific studies on poisons and nerve injuries shaped ideas that would emerge later in his Rest Cure and his fiction. By studying his letters, autobiography, case notes, and early scientific monographs at the College of Physicians, I learned that Mitchell's first twenty years as a doctor and scientist had a much greater impact on his concept of individuality than I could ever have imagined.

My comparison of Mitchell's literary and scientific writing is part of a larger project, *The Cell and the Self: Identity in Nineteenth-Century Literature, Science, and Politics* (forthcoming, Johns Hopkins University Press), in which I explore the way that ideas about cells, germs, and individual people were interrelated. By examining the writings of four physician-authors—Mitchell, Santiago Ramón y Cajal (1852–1934), Arthur Conan Doyle (1859–1930), and Arthur Schnitzler (1862–1931)—I have discovered that they often expressed their ideas about cells and persons in the same terms. They frequently defined the individual living unit according to boundaries and any

penetration of these boundaries as a threat to the unit's identity. This reliance on borders, I have become convinced, had a cultural and political basis. How did scientists and creative writers develop this need for boundaries in their notions of selfhood? How did scientific vision combine with artistic and cultural needs to make them see an individual as an intact, independent unit? I brought these questions to Mitchell's writings, particularly material from 1850–70, and saw his view of selfhood as resistance to outside forces emerging from his earliest medical experiences.

Mitchell's father, J.K. Mitchell (1790–1858), had been an early advocate of the germ theory, the belief that diseases are caused by living microorganisms. He was also a skilled hypnotist and a believer in mesmerism. Reading J.K. Mitchell's essays at the College, I saw again the intriguing affinity of interests that surfaced in each of the four physician-authors I have studied. Both of J.K. Mitchell's interests encourage concerns about invasion; in germ theory bacteria invade the body, in hypnosis suggestions alter the mind. S. Weir Mitchell's letters home while he studied medicine in Paris from November of 1850 to April of 1858 show how deeply his father influenced his medical views. In these letters he repeatedly mentions books on "fungi" and magnetism that he will be sending home. Describing Robin's course on microscopy, he wrote, "I hear that you expect me to rival you at this. I fear not" (5 Feb. 1851).

While in Paris, Mitchell became intensely interested in microscopy, developing a curiosity and an eye for detail that forever shaped his medical vision. The most important discovery I made at the College, a completely unexpected finding, was the degree to which the French physiologist Claude Bernard (1813–1878) influenced Mitchell's thinking. Bernard, who advocated active physiological experimentation in order to understand how the human body worked, was studying the nervous system when Mitchell was in Paris, and it is possible that Mitchell grew as interested in Bernard's subject matter as he did in his approach. Bernard viewed the body as a great machine, an assembly of interdependent systems. A living organism, while always influenced by the external environment, could also resist outside forces and maintain its own *milieu intérieur*, an intermediate environment determining and determined by the body's own cells and organs. Although Mitchell's actual interactions with Bernard were brief, his frequent and respectful references to Bernard in his physiological studies reveal his enormous indebtedness to the French physiologist.

In order to learn how the body worked, Bernard had used poisons that could disable one particular system at a time and Mitchell followed his lead. Between 1860 and 1870, Mitchell published analyses describing numerous poisons and their mechanisms, finally focusing on rattlesnake venom, about which little was known. Mitchell's snake venom studies are systematic and thorough, carefully analyzing the behavior, anatomy, chemistry, and physiology involved. Of particular interest to him was the means by which the poison penetrated the body. As a doctor, Mitchell appears to have identified with the rattlesnakes, comparing their fangs to needles and their poison glands to "rival drug shops" (1868, pp. 44–55). His writing also reveals a horrified fascination with piercing and injection based on an association with sexuality. He finds that the poison gland "resembles very strikingly, in section, the appearance of a small testicle" (1860, p. 12). Mitchell's studies with poisons provide devastating images of healthy animals pierced, infiltrated, and physiologically sabotaged. These early experiments encouraged him to view the individual as vulnerable, successful at living only as long as she or he could resist "poisonous" thoughts that threatened to invade his or her system.

When the Civil War erupted, Mitchell was forced to abandon his physiological studies, but he retained his attention to detail and his belief that local disturbances in the body affected and revealed the operation of broader physiological systems. His thousands of pages of notes on his Turner's Lane Hospital patients, 1863–64, attest not only to his scientific eye but to his ear for language and his powerful human sympathy and curiosity. Mitchell asked his nerve-injured patients detailed questions about how they were shot, but more importantly about exactly how they felt and about the quality of their pain. One patient reported a burning "like mustard," not relieved by the application of water; another, like Poe's Roderick Usher, found that any sound, even music, made his "screwing" pain unbearable. One sees Mitchell's potential as a storyteller in his account of how one soldier, when hit, had felt as if he had been struck in the back by a stick and had been so sure of it that he had turned around to accuse the man behind him (1864, pp. 14–15).

Mitchell's popular scientific works, *Wear and Tear* (1873), *Fat and Blood* (1877), and *Doctor and Patient* (1888), develop the ideas about identity and pathology that his physiological and neurological research first suggested. Citing numerous cases, he tried to convince readers that to cure an exhausted mind, one must cure the entire body. His Rest Cure, based on the treatment of confinement, over-

feeding, faradization, and massage that he had devised for wounded soldiers, was intended to restore the "economies" of nervous patients, almost all female. An aggressive intervention in a failing system, Mitchell's treatment attempted to reestablish restraint, control, and will power, for him the most essential qualities of human identity. He envisioned convalescence as a "self-conquest," "a slow, hopeful, steady training of the will" (1880, p. 70). In his novels, his "nervous characters" fulfill his wishes by responding to treatment, like Sibyl Maywood in *Doctor North* (1900) who "swiftly gained in health, and with it self-control" (p. 212). It becomes clear, as one reads Mitchell's scientific essays and his novels that he associated openness and penetrability with pathology. His patients are ill because they have "let in" their own emotional impulses and dangerous suggestions from those around them, and they are cured when they reestablish the barriers protecting them from their own and others' desires.

In a speech honoring the University of Pennsylvania's new Hygiene Institute, Mitchell calls flasks of bacteria a "Pandora's box of pathological disaster" (1892, p. 4). If one compares this description to his claim that the nervous woman "has acquired within herself a host of enemies," one sees the relationship between his vision of external, biological threats, and internal, psychological ones. Health, to Mitchell, means the ability to maintain boundaries and to resist external and internal threats: germs, to which he refers frequently, and emotional and sexual impulses, to which he refers rarely, if at all.

I am grateful to the Wood Institute for supporting my investigation of Mitchell's early scientific writing, writing which has so far received insufficient attention from scholars. Without this access to his letters and case notes, I would never have fully understood the development of his thinking. Mitchell is not a popular figure at present. His assertions about women's limited intellectual capacity and his denial of their views of their own illnesses enrage most contemporary readers. When one examines his original notes and letters, however, one is able to see evidence of sympathy and intellectual curiosity that modify his image as sexist and authoritarian. If he crushed the individuality of his female patients, he did it to reestablish their sense of identity as he understood it.

* * *

Carla Gerona

Stairways to Heaven: A Cultural History of Seventeenth- and Eighteenth-Century American Quaker Dreams

My dissertation, "Stairways to Heaven: A Cultural History of Seventeenth- and Eighteenth-Century American Quaker Dreams," is a study of dreams and their interpretations in the early American Quaker community. The central argument proposes that dreams provided Quakers with a powerful vehicle for shaping the values of an emerging colonial society. "Night vision," as Quakers often termed their dreams, contributed to social and cultural changes as wide-ranging as the abolition of slavery and religious reform. Simultaneously, dreams helped Quakers define and delineate their mission in America, fostering innovative concepts of individuality, community, and nation. Because Quakers emphasized the religious significance of dreams, believing that God sent messages through them, they disclosed their night visions with great urgency and frequency. They recorded them in letters, copybooks, journals, religious tracts, and meeting notes. The people who shared dreams with friends and recounted them in meetings often interpreted them skillfully in order to increase their religious authority.

Disenfranchised individuals, such as women, African Americans, Native Americans, and servants could advance alternative ideas when they expressed their concerns in dream accounts. Although these dreams sometimes presented a challenge to conventional understandings of well-ordered society, Quaker leaders, including doctors, did not deny the importance of dreams and visions. In fact, ministers and elders mobilized dreams for their own ends. In particular, leaders promoted dreams that cultivated self-discipline, individual conscience, and distinctive gender roles. In their totality, then, dream accounts advanced a collective Quaker vision that balanced Christian discipline with a sense of democratic universalism. American Quakers in Pennsylvania, and throughout the British colonies, did not keep their dreams to themselves. At their most effective, Quaker dreams circulated beyond meetinghouse walls and influenced important reform movements in America.

The College of Physicians of Philadelphia furthered my research on several fronts. First of all, the College's collection introduced me

to the work of Thomas Tryon, a seventeenth-century dream theorist. Tryon was a religious seeker who wrote primarily about diet, went to Friends' Meetings, and published his works with a Quaker press. Tryon believed that he could uncover the mystery behind dreams and make them useful to vigilant seekers. According to Tryon, angels visited upstanding people in their sleep and favored them with pleasant dreams; demonic forces sought out evil people and gave them nightmares. He therefore beseeched his readers to examine their conscience through a study of their dreams. For those readers who found their dreams disturbing, Tryon suggested a physical antidote. He urged temperance in food, drink, and thought. Thus restraint, rather than zealousness, provided the key to effective spiritual communications with God. This linkage of morality, spirituality, and physicality helped Quakers resolve new contradictions in their religious beliefs. In order to regulate their society, Quakers sought to bridle the more mystical tendencies in their religion, but they did not seek to completely eradicate the spiritual "inner light" that connected all Quakers to God. The triangulation of moral, spiritual, and physical forces that marked Tryon's dream theory enabled Quakers to maintain the spiritual value of dreams, while infusing dreams with new and more rational ideals. Tryon's explanation of dreams provided a theoretical framework that enabled a changing Quaker community to continue to endorse the importance of dreams and to continue to use dreams as powerful tools of influence.

The College's historical collection included many other sources that helped me understand the general context within which people interpreted their dreams during the early modern period. For example, Richard Saunder's *Physiogomie and Chiromancie*, published in 1671, drew on astrological and astronomical knowledge to explore the predictive qualities of dreams. Another book, "Le Palais des Curiex," from 1738, coupled dreams with fortune-telling—a practice that most Quakers would have abhorred. The College's collection also revealed some significant silences. The eighteenth-century medical journals, in particular, suggest that physicians did not engage in any major studies of dreams, though one article discussed the case of a mute, Henry Axford, "who recovered the use of his tongue" after a frightful dream. A few articles appeared on unusual sleep patterns. But a more intensely physiological approach to understanding dreams, associated with Benjamin Rush, did not emerge until the end of the eighteenth century. Rush's close contact with the Quaker community may explain his deep interest in the subject of dreams.

In addition to his careful physiological studies of dreams, Rush's commonplace books reveal an awareness and respect for the moral appreciation of dreams cultivated by Quakers. Nonetheless, Rush's account of the yellow fever epidemics contrasts enormously with the visionary dream experiences that Quakers recorded during these difficult periods. In the future, I hope to explore some of these differences of dream interpretation that emerged at the end of the seventeenth century.

The College always provided a wonderful atmosphere for work. The librarians and archivists were extremely helpful and friendly. I also found the College, with its knowledgeable staff, lunch seminars, and excellent museum, to be an extremely stimulating intellectual environment. I look forward to my presentation next year and hope to continue using the collections in the years to come.

* * *

Karol Weaver

Syphilis and the Imperialist Outlook: The Careers of Richmond Holcomb and Charles S. Butler

My period of research at the College of Physicians of Philadelphia was very rewarding. My initial question was whether the naval service of Richmond C. Holcomb influenced the conclusions he drew about the origins of syphilis. Richmond Holcomb was a well-known, early-twentieth-century, pre-Columbian theorist, who believed that syphilis existed throughout the world long before Columbus returned from the Americas. The Historical Library of the College of Physicians possesses original materials, photostats, photographs, documents, and papers from Dr. Holcomb. Much of this collection concerns Holcomb's work on the history of syphilis. I expanded my inquiry to include the works of Charles S. Butler, an associate of Holcomb, a fellow naval officer and pre-Columbian scholar, after finding numerous articles written by Butler in naval and military medical journals housed in the College's library.

The results of my research were richly diverse. I was able to produce a paper entitled "Syphilis and the Imperial Outlook," where I argued that the participation of Holcomb and Butler in the

United States colonial activity contributed to their conclusions about syphilis. Their imperial outlook was crucial to their findings about the illness and the efforts made by the United States military to protect its conquering soldiers and sailors from the diseased populations it meant to "civilize." Holcomb and Butler's study of syphilis in territories occupied by the American military, such as Guam, the Virgin Islands, and Haiti, was tied to the twentieth-century movement by United States officials to stop the spread of syphilis, particularly among military personnel. Butler especially sought to arrest the transmission of syphilis from "native" peoples to sailors. This imperial outlook was reflected in the patriotic zeal with which the two naval officers argued for the pre-Columbian theory. It was also evident in their support for the unitarian theory of syphilis which holds that syphilis and other trepenomal infections such as pinta and yaws are simply different clinical manifestations of one trepanomatosis. Finally, the imperial outlook appeared clearly in the racism exhibited by Butler in his many articles on the origins of syphilis. I presented these findings at the Wood Seminar for the History of Medicine at the College of Physicians of Philadelphia in February 1997. In addition, this paper was read at the Joint Atlantic Seminar for the History of Biology and Medicine at Yale University School of Medicine in April 1997.

My fellowship also gave me the opportunity to use the Library's collection of eighteenth-century medical books on disease in the French West Indian colony of Saint Domingue. These works include Jean Barthélemy Dazille's *Observations sur les maladies des nègres* (1792) and *Observations sur le tètano* (1788), Jean-Baptiste-René Poupée-Desportes' *Historie des maladies de S. Domingue* (1770) and *Medécine domestique de Saint Domingue* (1802), Antone Poissonnier-Desperrières' *Traité des fièvres de l'ile des Domingue* (1763), Jean Damien-Chevalier's *Lettres à M. Jean* (1752), and Joseph Jacques de Gardane's *Des maladies des creoles on Europe* (1786). This research lead me to broaden the scope of my doctoral thesis from a study of syphilis to a history of disease in eighteenth-century Saint Domingue. My project focuses on what diseases existed among the diverse populations of Saint Domingue during the eighteenth century. These populations included white colonists, the sang-melés (literally, the mixed-bloods), and African and creole slaves. As part of my thesis I will be exploring the roles that race and gender played in the identification and treatment of disease. The primary source materials at the College allowed me to draft the doctoral proposal that was approved by my committee at Pennsylvania State

University in February 1997. My research at the College also contributed to a successful application for the Hill Fellowship, a research award offered by the Pennsylvania State University Department of History.

I appreciate the honor of having been chosen as a Wood Institute Resident Research Fellow. I look forward to visiting the College in the future in order to continue my research there.

* * *

Nancy Cervetti

The S. Weir Mitchell Papers

In 1990 the College of Physicians acquired the S. Weir Mitchell Papers, a large collection containing travel journals, correspondence, diaries, literary notebooks, manuscripts of speeches and poems, and a 300-page typescript of Mitchell's unpublished autobiography. In the collection there are approximately 800 letters written by Mitchell to other physicians, patients, literary figures, and friends such as William Dean Howells, Oliver Wendell Holmes, Andrew Carnegie, George Meredith, and Sir William Osler. The letters preserve Mitchell's personality, style and tone, and reveal the genesis and evolution of his ideas. There are two smaller collections, one consisting of 170 letters between Mitchell and Amelia Gere Mason and the other consisting of 106 letters between Mitchell and Sarah Butler Wister. These lengthy conversations, often explicit, particular, and intimate, present an engaging dialogue regarding a variety of social and literary topics. As a short-term Resident Fellow of the Wood Institute, I was able to work with the Mitchell Papers for six weeks.

My interest in S. Weir Mitchell began while working on my dissertation, a part of which dealt with medical discourse and the life and writing of Virginia Woolf. While reading articles about women published in the *British Medical Journal* from 1880 to 1920, I frequently came across highly commendatory references to Mitchell and his rest cure. Yet, in considering the tone, wit, and insight of Woolf's letters alone, clearly, she could not have made a suitable patient for the cure, which required total isolation, sensory deprivation,

a fattening diet, and little to no reading or writing. In addition, total obedience to the doctor was essential for success. Woolf underwent the cure on four different occasions, and she disliked it intensely. A few days before her suicide, she explicitly refused to undergo the cure again. It appears that those who accepted the patriarchal ideal of "woman" as submissive, ornamental and reproductive in purpose were helped by the rest cure, returning home to assume their roles as wives and mothers. However, for others like Virginia Woolf and Charlotte Perkins Gilman who struggled to subvert this reductive view of women, the cure was unhealthy and harmful.

In addition to the rest cure, Mitchell participated in several other major facets of nineteenth-century American culture: early medical training, Civil War medicine, toxicology, neurology, advocacy of dominant social and cultural ideology, Philadelphia high society, and the development of the modern doctor-writer. His concern with the war and political and ethical issues, his views on women and education, and his comments on topics as diverse as poetry, vivisection, and athletics enlarge and elucidate our understanding of the man and his context.

My time as a Wood Institute Research Fellow directed my research with Mitchell in two different directions. First, because Mitchell saw himself as a "literary physician" and because he published numerous medical and literary books, articles and stories, he provides a valuable occasion to study the relationship between literature and medicine. His work helps clarify the way certain metaphors and plots pass between literary and medical discourse. His medical as well as literary efforts also reveal a great deal about the imaginative qualities of nineteenth-century scientific endeavors. I have been focussing on how literature and science were united for Mitchell through a "moral" imagination, and, more generally, on the place of morality in medicine and literature.

Second, my current research also examines nineteenth-century medical books, not only the ones Mitchell wrote but the ones that appeared on the Recommended Reading List for Jefferson Medical College while he was a student there. These books include the French medical textbook *A Treatise on the Diseased and Special Hygiene of Females,* written by Marc Colombat and translated into English by Charles D. Meigs. Meigs, who was a friend of Mitchell's family and Professor of Midwifery and the Diseases of Women and Children at Jefferson, translated Colombat's book in 1845, and in 1848 he published his *Females and Their Diseases; A Series of Letters to His Class*, which in tone and content conspicuously resembles Colom-

bat's book. Thomas Addis Emmet attended Jefferson at the same time as Mitchell, and they graduated together in 1850. Emmet is often referred to as one of the great founders of modern gynecology, publishing *The Principles and Practice of Gynaecology* in 1879, a book referred to in the *Dictionary of American Medical Biography* as the "first thoroughly scientific, comprehensive book on this subject in English." Several editions of Emmet's book appeared in the 1880s, and it was translated into French and German. In reading the book, one quickly sees that although published thirty-one years after Meigs' book, the tone and content have changed little, demonstrating the impact of the Colombat and Meigs influence.

The powerful Jefferson Medical College nexus of influence based on Colombat's textbook, Meigs', Emmet's, and Mitchell's work shows that attitudes and physiological concepts spread from the medical centers of Edinburgh, London and Paris to Boston and Philadelphia, thus becoming foundational to the American medical community and part of our cultural fabric. Jefferson Medical College, like many early American medical institutions, felt the influence of Britain and the Continent, especially in terms of the medical textbooks used. Along with Colombat's book, Fleetwood Churchill's book on midwifery was on the recommended reading list during the years Emmet and Mitchell attended Jefferson. Churchill, a British obstetrician and medical writer, studied medicine in London, Dublin, Paris, and Edinburgh.

Early American doctors frequently went to Great Britain and Europe for medical training. Benjamin Rush graduated from the University of Edinburgh, and the first medical college in the colonies was established in Philadelphia by William Shippen, Jr., and John Morgan, both of whom had trained in Edinburgh. In addition to French, Meigs also studied German until he was able to read with ease the most important German obstetricians. In summarizing the importance of foreign medical education for American doctors, Erwin H. Ackerknecht refers to the "Edinburgh period" and later a "Paris" and a "German" period in the history of American medicine. Thus, through medical training, textbooks, and other publications, ancient and deep-seated ideas crossed the Atlantic in the late eighteenth and early nineteenth centuries and determined how New World doctors would think about and treat women's health and welfare.

* * *

Jennifer S. Tuttle

S. Weir Mitchell, Medicine Man: Race, Gender, and Medical Authority in Mitchell's West Cure

Among literary scholars, S. Weir Mitchell is best known for his treatment of Charlotte Perkins Gilman, whose scathing story "The Yellow Wall-Paper" (1892) fictionalized aspects of her experience with Mitchell's Rest Cure for neurasthenia. Mitchell's cure, as well as his prescription that Gilman "live as domestic a life as possible" in order to achieve healthy femininity are diametrically opposed to his lesser-known treatment of the neurasthenic novelist, Owen Wister. Two years before treating Gilman, Mitchell recommended that Wister undertake a curative visit to a Wyoming cattle ranch, a treatment that Wister fictionalized in his Western novel *The Virginian* (1902). My comparative analysis of Gilman and Wister's cases suggests that literary scholars as well as historians of medicine have based their understanding of Mitchell on an incomplete understanding of his treatments. Elsewhere, I have argued that the Rest Cure and the West Cure were not only equally familiar to Mitchell's contemporaries but that they also comprise complementary parts of one process through which normative gender identities were constructed and reinforced in the United States during the late nineteenth century. A Francis C. Wood Resident Research Fellowship allowed me to further develop these ideas by incorporating Mitchell's travel journals, unpublished autobiography, correspondence, lectures, speeches, and photographs into my analysis of his published writings, both literary and medical, on the West Cure. The result has been a more complete and nuanced understanding of Mitchell's treatment of neurasthenia and of the assumptions about gender, race, and medical authority from which he derived his approach.

In his well-known book *Wear and Tear, or Hints for the Overworked* (1871), Mitchell deplores middle- and upper-class men's unhealthy immersion in the hectic pace of city life and the mental demands of business, which he sees as the primary causes of neurasthenia in men. In his less-familiar essay, *Camp Cure*, first published during the early 1870s, Mitchell recommends a treatment for this condition. Addressing lay persons rather than medical specialists, Mitchell urges his reader to escape, not to a sanatorium or hotel, but to a camp in the wilderness. By hunting or fishing for his food,

Photograph of S. Weir Mitchell (seated in center) prior to a trip to Michigan.
Collection of the Library of the College of Physicians of Philadelphia

chopping his own wood, and sleeping out in the open, the male neurasthenic would see his effeminating ills vanish, replaced by a masculine vigor. This quest for renewed health was not undertaken alone. A crucial part of the therapy involved the rejection of feminine society and an embracing of masculine community. Although women appear occasionally in Mitchell's writing about the West Cure, they generally represented the pathologized femininity that must be overcome by the treatment. The masculine community of the camp included eastern health-seekers, the trappers and woodsmen they encountered in the wilderness, and the male cooks and Native American guides they employed. For Mitchell, the West Cure was a "return to barbarism," a curative journey to be accomplished through the neurasthenic's emulation of these representatives of "barbarous" masculinity (i.e. uncivilized, non-white, working-class). The central project of the West Cure, however, was not the rejection of civilization and its privileges, but rather an appropriation of the wild, the "barbarous," and the "uncivilized" so that the neurasthenic upper classes could reclaim a powerful, superior ideal of manliness which Mitchell thought that they had lost. The goal of the cure was to return the previously debilitated man to his home in the East, newly invigorated so that he could continue the work of furthering American civilization.

The S. Weir Mitchell papers at the Historical Library of the College of Physicians of Philadelphia richly supplement Mitchell's published writings on the West Cure. One of the most important concepts that these documents reveal is the extent to which Mitchell defined the cure as the absorption of Native American culture and identity. This fact is readily evident in a photograph of a young Mitchell preparing for one of the countless health-giving forays into the wilderness of the Great Lakes, upstate New York, Maine, and Yellowstone Park that he made throughout his life; this one took him to Lake Superior during the 1860s. The photograph shows Mitchell as part of a community of men, dressed in rough camping garb and flanked by two men who appear to be Native American guides—one holds an axe. It is these two who will presumably lead the group from "civilization" and direct their "return to barbarism." This powerful visual image is reinforced by Mitchell's writings. When Mitchell recommended the health benefits of "wood life" to medical students during a lecture in 1908, he invoked "Indian" wisdom as his source. References to Native Americans and their customs are widespread in the travel journals through which he chronicled his own West Cures. As he noted in his journals, Mitchell's

adventures in the wilds of the Great Lakes and Wyoming brought him into contact with indigenous peoples. His interactions with these peoples ranged from trade near Lake Superior in 1871 to distrust when, on an 1874 trip to Lakes Superior and Nipigon, he reports that some "Indians" tried to steal his dressing case. In 1879, he worries that those inhabiting Yellowstone might be "hostile or predatory" (July 13th). Mitchell also established a special relationship with a young man of mixed parentage, a "half breed" as he puts it, named Julius Cadotte. Mitchell repeatedly hired Cadottte as his guide through the Great Lakes. Mitchell's journals illustrate that meticulous and scientific observation, reenactment, and appropriation of Native American skills, practices, language, and lore were key elements of his travel experiences. Mitchell recorded instructions (often accompanied by illustrations) for making a bundle in the "Chippeway fashion" (Lake Superior, 1870) as well as for building an Indian canoe (Lake Nipigon, 1874). He described an Indian moccasin game in great detail and maintained a list of Chippewa phrases (Lake Nipigon, 1874). Occasionally he mentions hearing Indian tales around the campfire.

A journal entry from Mitchell's 1871 trip to Lake Superior provides significant insight into his relationship with Native American culture and practices. The entry describes an encounter during which the group's members were assigned Indian names, Mitchell's being, of course, "Medicine man." This moniker neatly embodies Mitchell's role as both a partaker and a prescriber of the West Cure, in which "playing Indian" was often an integral part of his "return to barbarism." The cure's multi-faceted appropriation of Native American identity indicates, in fact, the extent to which it participated in larger cultural processes that facilitated American expansion during the second half of the nineteenth century. Like other icons of the American frontier, such as Teddy Roosevelt (himself an advocate of the West Cure), Daniel Boone, and Davy Crockett, the West Cure participant was supposed to see himself as simultaneously akin to and superior to the masculinized racial Others inhabiting the West. This process allowed an expansive ideal of American "civilization" to be forged and reaffirmed as has been argued by Gail Bederman, Michael Kimmel, Richard Slotkin, and others.[1]

---

[1]Gail Bederman, *Manliness and Civilization: A Cultural History of Gender and Race in the United States, 1880–1917* (Chicago: University of Chicago Press, 1995); Michael Kimmel, *Manhood in America: A Cultural History* (New York: The Free Press, 1996); Richard Slotkin, *Regeneration Through Violence: The Mythology of the American Frontier, 1600–1860* (Middletown, CT: Wesleyan University Press, 1973), and *The Fatal Environment: The Myth of the Frontier in the Age of Industrialization, 1800–1890* (New York: Atheneum, 1985).

As Mitchell's Indian name suggests, his interest in the West Cure was both professional and personal. In addition to prescribing the cure for others, he frequently took it himself. The S. Weir Mitchell Papers indicate, in fact, the ways in which the West Cure was a crucial part of Mitchell's self-definition as an individual and as a physician. Although some published materials already suggest this, the papers housed at the College of Physicians greatly clarify scholars' understanding of Mitchell's investment in the cure. In addition to his travel journals, which comment frequently on the salubrious effects of the treatment, Mitchell's unpublished autobiography (ca. 1900) traces the treatment's origins. Mitchell discusses his own attempts to overcome a nervous and sickly constitution and later illnesses due to overwork with outdoor sports and escapes into the wild. In his correspondence, Mitchell frequently described his yearly treks into the wilderness of Canada and Maine, enthusiastically detailing his "killing" of salmon and the renewal of his health and vigor (Mitchell to Sir Ronald Ross, 22 July 1907; to Amelia Gere Mason, 27 July 1908; and to Sarah Butler Wister, 1889). His correspondents were clearly aware of these aspects of Mitchell's life, writing to him in the language of the camp and concurring on the benefits of the West Cure (George Washington Cable to Mitchell, 21 November 1900; and William Osler to Mitchell, undated). This personal experience with the West Cure contributed to Mitchell's authority as a prescriber of the treatment. Although the best-known image of Mitchell is that of a dapper, urbane Philadelphia Brahmin, whose fiction was filled with witty drawing-room conversation and whose patients revered him for his dignified reserve, the Library houses a number of sources that suggest Mitchell sought to construct himself in more complex terms. In a 1907 speech given in Toronto on the "Country doctor," Mitchell attempted to establish a rapport with his audience by describing his adventures tramping through Canada's forests and sailing its waterways. In the aforementioned lecture to medical students in 1908, Mitchell spoke from his own experience, recommending yearly West Cures as preventive medicine for his fellow healers. His visual self-representation also confirms this argument. In addition to the photograph described above, the Historical Library of the College of Physicians owns a picture of an older Mitchell, standing in hiking clothes among the trees of Bar Harbor, Maine, still presenting himself as an avid practitioner of the outdoor life. Most telling, perhaps, is a passage in his unpublished autobiography, in which he claims to be the first to propose the "open-air treatment." This clear investment in being an authority on the West Cure is confirmed in Mitchell's novel *John Sherwood*,

Photograph of S. Weir Mitchell in Maine.
Collection of the Library of the College of Physicians of Philadelphia

Ironmaster (1911). Sherwood is suffering from deteriorating health when he reads an essay called *Camp Cure* and is inspired to follow its advice. His health is restored following a curative sojourn in Bar Harbor. The Library's Mitchell collection clarifies, therefore, the relationship between Mitchell's construction of himself as an individual and his self-definition as a medical authority. He earns his status as a "Medicine man," as a healer of ailing masculinity, by taking the "barbarous" cure himself.

Despite Mitchell's choice of adjectives, the West Cure was in fact anything but "barbarous." Many of the Mitchell papers prove what is already partially evident in *Camp Cure*. Despite vociferous calls to leave behind "civilized" luxuries and to be self-sufficient, the cure was in fact enabled by servants, guides, and other laborers who, though ever-present (as the travel journals document), are rarely mentioned except when they help to define the hyper-masculine wilderness. Similarly, the cure relies on the technologies of civilization, including the thermometer and the sketch-book with which Mitchell urges the sickly man to record his experiences in the wild—a marked contrast to his recommendation that women Rest Cure patients refrain from writing. The request for scientific observation, which Mitchell followed himself when he recorded aspects of Native American life, can be understood as part of the appropriative process underlying the West Cure. It is probably not an accident that this impulse to diagnose, catalogue, and, therefore, master the wilderness paralleled the skills of Mitchell's own professional calling as a physician. The S. Weir Mitchell Papers are a rich resource for research into the West Cure. They also clarify the processes underlying Mitchell's self-representation as an eminent Philadelphia neurologist, whose utterly "civilized" public demeanor is enhanced, rather than threatened, by his "barbarous" adventures in the wilderness. I cannot say enough to thank the staff of the Historical Library for their interest and their efficiency, and to the College of Physicians for their financial support. The research I accomplished at the Library greatly enriched my manuscript, *Empire of Sickness: Literary Professionals and Medical Discourse in the Age of American Nervousness, 1869–1911*, and helped me to complete "Rewriting the West Cure: Charlotte Perkins Gilman, Owen Wister, and the Sexual Politics of Neurasthenia," which will appear in *The Mixed Legacy of Charlotte Perkins Gilman*, ed. Catherine J. Golden and Joanna S. Zangrando (Newark: University of Delaware Press, 1999).

* * *

In May of 1996 the College and the Wood Institute sponsored a seminal conference on Hippocrates and Modern Medicine. Initiated by former Scholar-in-Residence, David Cantor, Ph.D., the conference explored the multiple uses, meanings and constructions of Hippocrates and Hippocratic medicine since the seventeenth century. The College President, Alfred P. Fishman, M.D. provided the opening remarks for the conference. His keynote address is reprinted below. Additional papers presented during the conference have been assembled in an edited volume scheduled for release in 1999. A discount will be available to Fellows of the College interested in purchasing the volume.

Scolar Press and the Ashgate Publishing Group proudly present

Hippocrates and Modern Medicine
David Cantor, editor

Introduction: DAVID CANTOR

Hippocrates and the Construction of "Progress" in Sixteenth- and Seventeenth-Century Medicine
THOMAS RUETTEN

The Power of Paternity: The Father of Medicine Meets the Prince of Physicians
HELEN KING

The Chemical Hippocrates: Paracelsian and Hippocratic Theory in Petrus Severinus' Medical Philosophy
JOLE SHACKELFORD

The Transformation of Hippocrates in Late Seventeenth-Century England
ANDREW CUNNINGHAM

The Uses of Hippocrates in Seventeenth- and Eighteenth-Century English Medicine
ROBERT MARTENSEN

Hippocrates, Bacon, and the Royal Society, 1700–1750
ANDREA RUSNOCK

Hippocrates and the Montpellier Vitalists in the French Medical Enlightenment
ELIZABETH A. WILLIAMS

The Rhetoric of Hippocrates in Nineteenth-Century French Medicine
ANN LABERGE

Contested Filiation: Competition for Hippocrates in Antebellum American Medicine
JOHN HARLEY WARNER

Hippocrates American-Style: The Oath in Twentieth-Century Popular Culture
SUSAN LEDERER

A Model for the New Physician: Hippocrates in Inter-war Germany
CARSTEN TIMMERMAN

The Name and the Word: Neo-Hippocratism in Inter-war Britain
DAVID CANTOR

Hippocrates, Holism, and Humanism in Inter-war France
GEORGE WEISZ

Hippocrates and Contemporary Medicine

Alfred P. Fishman

During the 1940s, while excavating the tomb of a distinguished Roman physician in the ancient city of Ostia Antica, archeologists uncovered a fractured bust and, nearby, a pedestal.[1] Carved into the pedestal was the opening triplet of the first aphorism of Hippocrates, "Life is short." The bust was seriously damaged but distinguishing features remained. These resembled the head on an ancient Roman coin that also carried the telltale Greek letters HIP. The conclusion seemed inescapable: of all the heads of Hippocrates that had been invented through the ages, this was the real Hippocrates of Cos, who lived in ancient Greece from 460 B.C. until 375 B.C. This was the Hippocrates whom Plato and Aristotle had identified as the outstanding healer of his time.[2]

The Hippocratic Collection or "Corpus"

Few of the writings that carry his name were written by Hippocrates. Indeed, of the sixty-odd pieces that have survived, only Epidemics I and III and possibly Prognostics are still attributed to the real Hippocrates.[3] The remainder of the Corpus consists of a collection of multi-authored pieces, some written before and many after, Hippocrates' lifetime, but all apparently catalogued under his name in

---

[1]G. Becatti, "Il Ritrotto di Ippocrate," *Pontifica Academia Romania di Archeologia* 21 (1945/6), pp. 123–141; G.M.A. Richter, *Portraits of the Greeks* (London: Phaidon Press, 1965); D.W. Richards, "Hippocrates of Ostia," *J.A.M.A.* 204 (1968), pp. 1049–1056.

[2]Aristotle, *Politics*, VII, 4, 1326a, as translated by Benjamin Jowett in *One Man in the Universe* (New York: Grammercy Books, 1943), p. 392; H. Cary, ed., *The Works of Plato*, vol. 1 (London: Henry G. Bohn, 1854); H. Cary, ed., *Protagoras*, 311, B (London: Henry G. Bohn, 1854), p. 239; Plato, *Phaedrus*, 270, C-E in H. Cary, ed., *The Works of Plato* (London: Henry G. Bohn, 1854), p. 349.

[3]K. Deichgraber, "Die Epidemien und das Corpus hippokraticum," *Abhandlungen der preussischen Adkademie der Wissenschaften: Phil-Hist Klasse* 3 (1933).

the library at Coan. Thus, instead of being the product of a single individual, the Hippocratic Corpus represents the works of many physicians with different backgrounds and beliefs, but who practiced the Hippocratic method of healing.[4]

The Hippocratic writings reveal a revolution in clinical medicine: instead of turning to the gods for help in dealing with the sick, the physician was to look for natural causes. The new paradigm is set forth in the Hippocratic writing on epilepsy often called the "sacred disease":

> I do not believe that the 'sacred disease' is any more divine or sacred than any other disease but, on the contrary, has specific characteristics and a definite cause . . .
>
> It is my opinion that those who just called this disease 'sacred' were the sort of people we now call witch doctors, faith healers, quacks and charlatans . . . If remarkable features in a malady were evidence of divine visitation, then there would be many 'sacred diseases' . . .[5]

After Hippocrates, generations of students and physicians used the case reports in the Corpus as their medical texts.[6] The Oath and the aphorisms underscore the importance of professional skills.[7] The natural history of diseases is described from beginning to end, with detailed accounts of the patient's appearance and symptoms, the setting in which disease occurred, and the mental state of the patient. Attention is drawn, for instance, to clubbing of the digits in a patient with an empyema.[8] A poor outcome is predicted for the patient with a certain kind of appearance, the so called "Hippocratic facies":

> The nose sharp, the eyes sunken, the temples fallen in, the ears cold and drawn in and their lobes distorted, the skin about the

---

[4]W.H.S. Jones, trans. and ed., *Hippocrates* (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1984); H.E. Sigerist, *A History of Medicine*, vol. II (New York: Oxford University Press, 1961), pp. 273–312; Oswei Temkin and C.L. Temkin, *Ancient Medicine* (Baltimore: The Johns Hopkins University Press, 1967).

[5]W.H.S. Jones, trans. and ed., *Hippocrates*, vol. 2 (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923), p. 139.

[6]L.I. Conrad, M. Neve, V. Nutton, R. Porter, A. Wear, *The Western Medical Tradition 800 B.C. to 1800 A.D.* (Cambridge, UK: Cambridge University Press, 1995); Oswei Temkin, *Hippocrates in a World of Pagans and Christians* (Baltimore: The Johns Hopkins University Press, 1991).

[7]W.H.S. Jones, trans. and ed., *Hippocrates*, vol. 4 (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923).

[8]W.H.S. Jones, trans. and ed., *Hippocrates*, vol. 2 (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923), Prognosis 2, pp. 33–37.

> face hard, stretched and dry, and the color of the face pale or dusky . . . if there is no improvement within the prescribed time, it must be realized that this sign portends death.[9]

The entire course of an ill-fated patient with fulminating diphtheria is succinctly described as well:

> The woman suffering from angina (sore throat) who lay sick in the house of Aristion began her complaint with indistinctness of speech. Tongue red, and grew parched.
>
> On the first day shivered and grew hot.
>
> On the third day, rigor, acute fever; a reddish hard swelling in the next, extending to the breast on either side; extremities cold and livid, breathing elevated; drink returned through the nostrils, she could not swallow, stools and urine ceased.
>
> On the fourth day, all symptoms worse.
>
> On the fifth day, she died.[10]

In addition to its reliance on specific clinical descriptions rather than mysticism, the Corpus provides therapeutic principles and regimens, directs attention to the fact that each new treatment is an experiment, recognizes the influence of environment on disease, and acknowledges the fallibility of the physician.[11] Disease is pictured as an imbalance of natural forces and the physician is seen as the agent to restore balance.[12]

The need for accurate prognosis recurs throughout the Hippocratic Corpus. Diagnosis is a lesser concern:

> It seems to be highly desirable that a physician should pay much attention to prognosis. If he is able to tell his patients when he visits them not only about their past and present symptoms, but also to tell them what is going to happen, as well as to fill in the details they have omitted, he will increase his reputation as a medical practitioner and people will have

---

[9]Hippocrates, Prognosis 2, p. 2.

[10]W.H.S. Jones, trans. and ed., *Hippocrates*, vol. 1 (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923), Epidemics III, Case VII, pp. 231–233.

[11]F. Clifton, *Hippocrates: Upon Air, Water, and Situation*, Second edition (London: Printed for John Whiston and Benjamin White, c. 1752).

[12]W.H.S. Jones, trans. and ed., *Hippocrates* (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923); H.E. Sigerist, *A History of Medicine*, vol. II (New York: Oxford University Press, 1961), pp. 273–312; Oswei Temkin and C.L. Temkin, *Ancient Medicine* (Baltimore: The Johns Hopkins University Press, 1967).

> no qualms in putting themselves under his care. Moreover, he will better be able to effect a cure if he can foretell, from the present symptoms, the future course of the disease.[13]

In keeping with the concern about prognosis, and recognizing that "it is impossible to cure all patients," the Corpus permits physicians to refuse to treat patients who cannot be healed.[14] A patient's inability to pay, however, is not a basis for denying treatment.

The various books that comprise the Corpus often refer to the "science" of medicine.[15] This "science" bears no direct relation to modern science. Hippocratic "science" was a form of empiricism. The term "science" simply referred to the use of observation, documentation, and repeated experience with specific medications as the means of making discoveries about the sick. The Hippocratic approach to hypotheses provides an indirect link to later scientific practice. Instead of conjuring up a hypothesis and finding a supernatural explanation for a disease, Hippocratic science viewed hypotheses as suppositions that required validation before they could be accepted.

The Hippocratic teachings, as edited by Galen, endured as a primary source of medical knowledge until the scientific revolutions of the sixteenth and seventeenth centuries.[16] Subsequently, a more actively experimental science took the lead in searching for the causes and mechanisms of disease. But, by the time of the scientific revolution, the Hippocratic Corpus had made an indelible mark on medicine that was to be reflected in the teachings of influential clinicians such as Ambrose Paré during the sixteenth century, Herman Boerhave during the eighteenth, and William Osler during the nineteenth and twentieth.[17] A key question for the twenty-first century is whether the advanced technology of this century, with its surfeit of diagnostic laboratory tests, will diminish the bedside skills of the physician by placing a greater demand on the interpretation of laboratory tests than on the Hippocratic tradition of personal contact with the patient.

---

[13]W.H.S. Jones, trans. and ed., *Hippocrates* (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1923), vol. I, Prognosis 1, pp. 9–10.
[14]Ibid., vol. 2, "The Art of Medicine," Section 8, pp. 203–205.
[15]Ibid., vol. 1, "Ancient Medicine," vol. 2, "The Art of Medicine."
[16]Oswei Temkin, *Hippocrates in a World of Pagans and Christians* (Baltimore: Johns Hopkins University Press, 1991).
[17]L. Edelstein, "The Hippocratic Oath: Text, Translation, and Interpretation," *Bulletin of the History of Medicine*, supp. 1 (1943); H.E. Sigerist, *A History of Medicine*, vol. II (New York: Oxford University Press, 1961), pp. 273–312.

Ethical aspects of the patient-doctor relationship are dealt with in the Oath and in Hippocratic writings entitled "Law," "Decorum," and "Precepts."[18] However, with few exceptions (see below), these writings deal more with professional courtesies than with questions of values and morality.[19]

The Oath

The following paragraphs appeared in the catalogue produced as part of the one hundred and fiftieth anniversary celebration of the American Medical Association's code of ethics:

> The Oath of Hippocrates, a brief statement of principles, has come down through history as a living statement of ideals to be cherished by the physician. This Oath was conceived some time during the period of Grecian greatness, probably in the fifth century B.C. It protected rights of the patient and appealed to the inner and finer instincts of the physician without imposing sanctions or penalties on him or her. Other civilizations subsequently developed written principles, but the Oath of Hippocrates (Christianized in the tenth or eleventh century A.D. to eliminate references to pagan gods) has remained in Western civilization as an expression of ideal conduct for the physician.[20]

In essence, the Oath is a pledge to maintain a high standard of professional conduct: by taking the Oath, the physician becomes part of a trans-generational group that follows the same principles in the practice of medicine. It is a moral pledge. And those who live up to the pledge can expect to enjoy an enhanced reputation which, in turn, will help them earn a better living.[21]

---

[18]W.H.S. Jones, trans. and ed., *Hippocrates* (Cambridge, Mass.: Harvard University Press, The Loeb Classical Library, 1984).

[19]Edward Pellegrino, "Toward an expanded medical ethics: the Hippocratic ethic revisited," in *In Search of Modern Hippocrates*, R.J. Bulger, ed. (Iowa City: University of Iowa Press, 1987), pp. 45–63; Thomas Percival, *Medical Ethics* (Manchester, 1803), p. 29.

[20]"Ethics and American Medicine: A symposium commemorating the 150th Anniversary of the American Medical Association and its 1847 Code of Ethics," March 14–15, 1997, Philadelphia, PA.

[21]L. Edelstein, "The Hippocratic Oath: Text, Translation, and Interpretation," *Bulletin of the History of Medicine*, Supp. 1 (1943), pp. 4–63; H. von Staden, "'In a Pure and Holy Way': Personal and Professional Conduct in the Hippocratic Oath," *Journal of the History of Medicine and Allied Sciences* 51 (1996), pp. 404–437.

Certain elements of the Oath indicate that it was pieced together at different times. For example, it is inconsistent that Hippocrates, the leading proponent of natural explanations of disease, would begin the Oath by calling upon Aesculapius and his two daughter goddesses, Hygiea and Panacea, for help treating the sick. It is one thing to respect the position of the gods as rulers of health and earth, but it is quite another to expect them to influence the course of disease.[22]

The Oath specifies certain key attributes of a qualified physician: competence, compassion, commitment, and caring. The physician is expected to respect and guard the confidentiality of the patient. And, above all, the physician is to consider the welfare of the patient before his own self-interest.

For the modern physician, some components of the Oath may seem to be anachronistic, others may appear self-serving. Nonetheless, the Oath did provide criteria for distinguishing between charlatan and healer and it has continued to serve as a moral compass for the medical profession.[23]

The First Aphorism

Generation after generation of medical students after Hippocrates revered and recited from memory the cryptic writings known as the aphorisms. These are about four hundred pithy statements of variable origin and quality. Among these, the most familiar and meaningful is the first aphorism:

> Life is short, the art long, the right time fleeting, the trial [of therapy] precarious, judgment difficult. It is not enough for the

---

[22]L. Edelstein, "The Hippocratic Oath: Text, Translation, and Interpretation," *Bulletin of the History of Medicine*, Supp. 1 (1943), pp. 4–63; W.S.H. Jones, *The Doctor's Oath* (Cambridge: The University Press, 1924).

[23]T.L. Delbanco, J. Daley, J. Walzer, M.A. Winker, "Above All 'Do No Harm,'" *J.A.M.A.* 274 (1995), pp. 75–76; E. Dickstein, J. Erlen, J.A. Erlen, "Ethical principles contained in currently professed medical oaths," *Academic Medicine* 66 (1994), pp. 622–624; W.J. Friedlander, "Oaths given by U.S. and Canadian medical schools, 1977," *Social Science and Medicine* 16 (1982), pp. 115–120; Edward Pellegrino, "Toward an expanded medical ethics: the Hippocratic ethic revisited," in *In Search of Modern Hippocrates*, R.J. Bulger, ed. (Iowa City: University of Iowa Press, 1987), pp. 45–63; D.W. Richards, "Hippocrates and History; the arrogance of humanism," in *In Search of Modern Hippocrates*, R.J. Bulger, ed. (Iowa City: University of Iowa Press, 1987), pp. 25–44; D.C. Smith, "The Hippocratic Oath and modern medicine," *Journal of the History of Medicine and Allied Sciences* 51 (1996), pp. 484–500.

> physician to do what is necessary, but the patient and the attendants must do their part as well, and circumstances must be favorable.[24]

The fourth word in this aphorism, "art," is the customary translation of the Greek "techné." Although often confused with the humanistic aspects of medical practice, techné actually has a much broader meaning that includes art, science, craft, trade, industry, and profession. In the aphorism, art signifies the mastery of the skills required to deal appropriately with the needs of the patient. In the tradition of the "empirics," these skills rely heavily on the use of symptoms as a means of gaining insight into the nature of disease. Techné was also based on treatments that had been proven by repeated experience.

The Modern Scene

If Hippocrates were to be reborn in 1997, he would be greatly troubled. At first, he would be overwhelmed by the flood of technology and information. This he might rationalize as the inevitable consequence of progress. Then he would be intrigued by newspaper headlines concerning breaches in medical issues. Why are ancient issues, such as abortion and physician-assisted suicide, presumably settled long ago by the Oath, still featured in the news?[25] Can it be true that large populations of humans were subjected to medical experiments without their knowledge or permission? Has this insufferable practice been arrested? Do individuals who now agree to participate in a trial really understand what they are getting into, in particular, the risks and the benefits?[26]

---

[24]Hippocrates, "Aphorisms," trans. W.H.S. Jones (New York: G.P. Putnam, 1931), p. 99.

[25]"Assisted Suicide," *New York Times*, June 11, 1997; "Court 9-9, Upholds State Laws Prohibiting Assisted Suicide," *New York Times*, June 27, 1997; R.J. Bulger, "A Dialogue with Hippocrates," in *In Search of Modern Hippocrates*, R.J. Bulger, ed. (Iowa City: University of Iowa Press, 1987), pp. 249–251.

[26]C. Daugherty, M.J. Ratain, E. Grochowski, C. Stocking, E. Kodish, R. Mick, M. Siegler, "Perceptions of cancer patients and their physicians involved in Phase I trials," *Journal of Clinical Oncology* 13 (1995), pp. 1062–1072.

Another cause for concern would be the erosion of the patient-physician relationship.[27] No longer is this a personal matter between patient and healer. Instead, all sorts of third parties intervene: employers, insurers, health maintenance organizations, and governmental agencies.[28] To add to the complexity of this interplay, many physicians now serve as employees of for-profit organizations. They have become "providers" and the patients are "clients." Hippocrates would be plagued by disturbing thoughts about the conflicts of interest this situation engenders. How can trust in physicians be maintained if physicians' employers reward them financially for doing less for their patients?

The more that Hippocrates would look, the more he would find disquieting. Patients' choice of physicians is restricted by third parties. Once under the care of a physician, the patient's treatment is increasingly guided by prescribed "pathways." Many individuals who need physicians are denied access to physicians because they cannot pay for the services they need.[29] Hippocrates' overall impression would be that medicine has become more and more of a business that is subject to external controls that favor the interests of investors over patient welfare.[30]

---

[27]E.J. Emanuel, N.N. Dubler, "Preserving the physician-patient relationship in the era of managed care," *J.A.M.A.* 273 (1995), pp. 323–329; J.K. Iglehart, "The struggle between managed care and fee-for-service practice," *New England Journal of Medicine* 331 (1994), pp. 63–67; B.D. White, P.A. Singer, M. Siegler, "Continuing problems with patient self-determination," *American Journal of Medical Quality* 8 (1993), pp. 187–193.

[28]C.M. Clancy, H. Brody, "Managed Care: Jekyll or Hyde?" *J.A.M.A.* 273 (1995), pp. 338–339; Council on Ethical and Judicial Affairs, A.M.A., "Ethical issues in managed care," *J.A.M.A.* 273 (1996), pp. 330–335; B. Culliton, "Managed care and conflict of interest," *Nature: Medicine* 2 (1996), p. 489; J.P. Kassirer, "Managed care and the morality of the marketplace," *New England Journal of Medicine* 333 (1995), pp. 50–52; D. Mechanic, "Managed care as a target of distrust," *J.A.M.A.* 277 (1997), pp. 1810–1813; A.S. Relman, "Medical Practice under the Clinton reforms—avoiding domination by business," *New England Journal of Medicine* 329 (1993), pp. 1574–1576; M.A. Rodwin, *Medicine, Money, and Morals: Physician's Conflicts of Interest* (New York: Oxford University Press, 1993); K. Swarz, T.A. Brennan, "Integrated health care, capitated payment and quality: the role of regulation," *Annals of Internal Medicine* 124 (1996), pp. 442–448.

[29]S.A. Obstbaum, "Should rates of cataract surgery vary by insurance status?" *J.A.M.A.* 277 (1997), pp. 1807–1808.

[30]M.A. Rodwin, *Medicine, Money, and Morals: Physician's Conflicts of Interest* (New York: Oxford University Press, 1993); L.B. Russel, M.R. Gold, J.E. Siegel, N. Daniels, M.C. Weinstein, "The role of cost-effectiveness analysis in health and medicine," *J.A.M.A.* 276 (1977), pp. 1172–1177.

Aside from the ethical issues that stem from the complicated interplay between patient, physician, and payer, the contemporary physician may be called upon to make decisions which the ancient ethical principles cannot handle.[31] These situations include the withdrawal of life support systems, the allocation of scarce resources, the involvement of human subjects in therapeutic trials, the use of artificial organs and organ transplantation as well as decisions in neonatal intensive care units.[32] Although "to do no harm" remains a guiding principle, each of these advances has unintended ethical consequences.[33] As the inventions, technology, and discoveries of modern science have lengthened life, they have raised critical questions about the quality of life, death, and dying.[34]

On the horizon for the modern physician is the bright prospect of genetic testing and therapy.[35] New genes are being discovered in rapid succession, each holding great promise for the treatment of a disease that is otherwise incurable. However, along with the bright prospects has come the worrisome reality that genetic testing will also reveal susceptibility to disease in individuals who are phenotypically normal. How can we protect the privacy of this genetic information about susceptibility to disease in a world of electronic records and information highways? Can we keep such information from prospective employers or insurers? Moreover, can an asymptomatic individual who carries an abnormal gene be considered "normal"?

---

[31]A.R. Jonsen, *The New Medicine and the Old Ethics* (Cambridge, MA: Harvard University Press, 1990); A.H. Moss, C.B. Stocking, G.A. Sachs, M. Siegler, "Variations in the attitude of dialysis unit medical directors toward decisions to withhold and withdraw dialysis," *Journal of the American Society of Nephrology* 4 (1993), pp. 229–234; President's Commission for the Study of Ethical Programs in Medicine and in Biomedical and Behavioral Research, "Deciding to forego life-sustaining treatment" (Washington, D.C.: Government Printing Office, 1983), pp. 82–89.

[32]D.J. Cook, G.H. Guyatt, R. Jaeshcke, J. Reeve, A. Spanier, D. King, D.W. Molloy, A. Willan, D.L. Striener, "Determinants in Canadian health care workers of the decision to withdraw life support from the critically ill," *J.A.M.A.* 273 (1995), pp. 330–335.

[33]R.H. Bulger, E.M. Bobby, H.V. Fineberg, *Society's Choices* (Washington, D.C.: National Academy Press, 1995).

[34]R.M. McCann, W.J. Hall, A. Groth-Juncker, "Comfort care for terminally-ill patients," *J.A.M.A.* 272 (1994), pp. 1263–1266.

[35]American College of Medical Genetics/American Society of Human Genetics Working Group on ApoE and Alzheimer Disease, "Statement on use of Apo-lipoprotein E testing for Alzheimer's disease," *J.A.M.A.* 274 (1995), pp. 1627–1629; C. Lerman, S. Narod, K. Schulman, C. Hughes, A. Gomez-Caminero, G. Bonney, K. Gold, B. Trock, et al., "BRCA1 testing in families with hereditary breast-ovarian cancer," *J.A.M.A.* 272 (1994), pp. 1263–1266; D.C. Wertz, J.H. Fanos, P.R. Reilly, "Genetic testing for children and adolescents," *J.A.M.A.* (1994), pp. 875–881.

The Relevance of the Hippocratic Tradition to Contemporary Medicine

In the face of dramatic changes in science, technology, and society, medicine is striving to preserve what it has been since the time of Hippocrates: a profession with its own goals, guiding principles, and values rather than a trade.[36] Hippocrates continues to be the Father of Medicine, and the Oath a statement about the ideal physician. Although parts of the Oath have repeatedly been rewritten as times have changed, the core elements continue to emphasize sensitivity to the needs and vulnerabilities of the sick, ethical behavior, a way of life dedicated to the service of others, and responsiveness to some higher good. In essence, modern versions of the Oath still call upon the physician to practice medicine in accord with the traditional values of non-maleficence, justice, beneficence, and confidentiality.[37]

Epilogue

Over the years, not only physicians but also philosophers, historians, philologists, and theologians have taken turns at scholarly reviews of the Hippocratic tradition and its influence on Western medicine. For these humanists who, by definition, are devoted to ideas, clinical medicine offers a proving ground where ethical principles of justice, individual rights, and moral obligations can be tested. The physician faces a different sort of challenge: how to preserve these values in practice at a time when medicine as a profession is under siege.

[36]R.H. Bulger, E.M. Bobby, H.V. Fineberg, *Society's Choices* (Washington, D.C.: National Academy Press, 1995).
[37]E. Dickstein, J. Erlen, J.A. Erlen, "Ethical principles contained in currently professed medical oaths," *Academic Medicine* 66 (1994), pp. 622–624.

"A deep fund of hatred and resentment": Clinical Encounters in Eighteenth-Century England

Lynda Stephenson Payne

In 1759 a London hospital surgeon and a country surgeon-apothecary published letters accusing each other of being cruel, inhumane, ungrateful, and contemptible, in a case they had handled jointly concerning the amputation of a gentleman's leg.[1] In the ensuing pamphlet war between the two men, three themes were hotly debated, with the protagonists insisting on widely different interpretations of these areas. First, they each accused the other of lying about the patient's wishes regarding his choice of a primary surgeon. Second, they argued over who had the right to dress the stump and, finally, there was the important question of whether the patient had been aware of which of the two surgeons had actually sawed through his leg during the amputation. Intriguingly, the gentleman-patient also entered this public debate. He accused the country surgeon-apothecary of "barbarity" in having cut off his leg without his express consent or even knowledge.

A flurry of works about John Gregory's publication of *Observations on the Duties of a Physician* in 1770 and Thomas Percival's *Medical Ethics; or, A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons* in 1803 have caused historians of medical ethics to ignore the immediate pre-Gregory era. To date, this period remains labeled as an age of medical etiquette rather than medical ethics.[2] In 1994 the historian Mary Fissell wrote that no "ethics particular to the surgery profession governed conduct."[3] Rather, she viewed appropriate surgical

---

[1]George Aylett, *A Genuine State of a Case in Surgery: Being a Full Refutation of Certain Particular Facts related by Mr. Bromfeild*, [sic] (London, 1759), p. 34.

[2]See Mary Fissell, " 'Innocent and Honourable Bribes': Medical Manners in Eighteenth-Century Britain," in Robert Baker, Dorothy Porter and Roy Porter (eds.), *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries* (Dordrecht: Kluwer Academic Publishers, 1993), pp. 19–45.

[3]Fissell, " 'Innocent and Honourable Bribes' . . . ," p. 19.

behavior as inculcated through the institution of apprenticeship and shaped by the general norms of master/servant and client/patron interactions. In short, early modern surgeons have been repeatedly characterized as bound by the more general codes of gentlemanly manners and honor. Driven by a highly competitive medical marketplace, they are seen as prudently following the rules of polite society rather than an objective moral code.

However, the absence of an explicit code of ethics has blinded us to the fact that during the mid-eighteenth century there were many self-conscious discussions about how medical men should behave individually and communally. Moreover, these debates involved not only appeals to personal propriety but to a higher collective good based on either religious faith, the traditions of classical learning, or the antiquity of the practice of medicine and surgery. The following analysis of Aylett and Bromfield's dispute in 1759 shows that the reforms promoted by Gregory and Percival in their codes of ethics had important roots in the preceding century. By concentrating on the range of motives behind the many attempts to resolve their argument, I show that the gentlemanly language employed by the two eighteenth-century surgeons masked deeper ethical concerns.

Medical disputes were far from rare in the eighteenth century, although posterity has often preserved only one side of the argument. As Dorothy and Roy Porter have so ably shown, the unregulated and fiercely competitive nature of the early modern medical marketplace made it crucial for licensed medical practitioners to carefully fashion themselves in order to gain the respect of their patients and of the unavoidable entourage of "friends" that attended at every bedside.[4] Engaged in a never-ending battle with barbers, mountebanks, bonesetters, doctoresses, and piss-prophets as well as other surgeons and physicians, medical men had to pursue "boundary maintenance," in order to discredit the opposition and retain the privilege of treating patients.[5]

My emphasis will be on the form of the dispute itself. The story involves a consultation between two surgeons and a patient, an amputation, and the aftercare of the stump. At first glance this was not a significant moment in medical history, but as David Harley and

---

[4]See Dorothy and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Stanford: Stanford University Press, 1989).

[5]The term is used by Mary Fissell in *Patients, Power and the Poor in Eighteenth-Century Bristol* (Cambridge: Cambridge University Press, 1991), p. 155. She acknowledges that it was first coined by Pierre Bourdieu.

others have shown, the contents of disputes often reveal the tensions inherent in everyday medical practice.[6] Eighteenth-century surgeons and apothecaries lived in a culture that relied more heavily on oral rather than written communications. They were literate but left few records. However, through eavesdropping on their disputes, we can observe rules, beliefs, and values otherwise left unspoken.

In this paper I focus on two areas. First I explore the accusations concerning the process of gaining access to the patient's body known as the consultation. Second, I analyze the bitter arguments surrounding control of the amputation itself and the aftercare of the patient. In each case I examine the facts as described by the surgeons and the patient, and set these within the context of eighteenth-century British views concerning the ethics of jointly consulting and operating on patients.

I. The Consultation

On October 29, 1759, William Bromfield (1712–1792), Surgeon to her Royal Highness the Princess Dowager of Wales and St. George's Hospital in London, published *A Narrative of Certain Particular FACTS, Which Have been misrepresented, Relative to The Conduct of Mr. Bromfeild* (sic) *toward Mr. AYLETT, a Surgeon and Apothecary of Windsor, during their Attendance on Mr. BENWELL at Eton,* priced at one shilling and including a long letter to the patient as well as Mr. Benwell's reply.[7] In forty pages Bromfield outlined the course of events which had led him to publish his dispute with one George Aylett, a country surgeon-apothecary. As was customary in such literature, Bromfield wrote in the first person and in the form of a letter to the patient.[8] "Mr. Benwell," he began,

> I must ask you to peruse and correct the enclosed narrative of my care towards you . . . and beg your permission to publish it; as the most scandalous falsities have been propagated not only in your neighbourhood of *Eton* and *Windsor*, and the

---

[6]See David Harley, "Honour and Property: the structure of medical disputes in eighteenth-century English medicine," in French, Roger, Cunningham, Andrew (eds.), *The Medical Enlightenment of the Eighteenth Century* (Cambridge: Cambridge University Press, 1990), pp. 138–164.

[7]William Bromfeild (sic), *A Narrative of Certain Particular Facts* (London, 1759).

[8]See Harley, "Honour and Property."

> country towns adjacent; but, also in the cities of *London* and *Westminster*: nay even the most distant parts of the kingdom have been furnished with libels intended to prejudice me in the esteem of my brethren.[9]

For Bromfield the "facts" were that, on Tuesday May 29, 1759, he received a letter from Aylett informing him that he and another local Windsor surgeon desired Bromfield to attend a Mr. Benwell, "who had forced the lower extremity of his Tibia through the Ligament of the joint."[10]

In a private meeting, all three surgeons quickly agreed that they must amputate the leg. Aylett then went upstairs to make Mr. Benwell "aware by degrees of their sentiments." The patient, not unusually in these cases, asked for time to think it over and, more importantly, to prepare his will. However, after Aylett left to go home, Bromfield claimed that Mr. Howard (the other local surgeon) asked him to perform the operation. Howard reportedly told Bromfield that as the Benwell family's surgeon, and the first to see the patient, he had every right to choose the actual operator. Yet Bromfield's case did not rest there, for he further reported that the patient also sent a note as Howard and he were dining to ask Bromfield to take the leg off. With the permission of the patient and the family surgeon in hand, Bromfield therefore rushed to prepare his dressings and instruments, adding that, having no apron or sleeves, he fashioned them from some woolen cloth provided by Howard's apprentice.[11] However, on arriving at the patient's home in full professional attire, Bromfield was informed that Mr. Aylett, the local surgeon-apothecary who had originally summoned Bromfield from London, was already upstairs with the patient. Aylett immediately came down and was

> much disconcerted and . . . surprised to see him so equip'd and stated Benwell was HIS patient and given Howard had chosen not to do the operation he had no right to appoint another and he should have been consulted before Benwell accepted it.[12]

---

[9]William Bromfeild (sic), *A Narrative of Certain Particular Facts* (London, 1759), p. 3. Neither Aylett nor Bromfield give any details of how the injury to Mr. Benwell occurred. An educated guess would be a horse-riding accident.
[10]Ibid., p. 4.
[11]Ibid., p. 8.
[12]Ibid., p. 9.

Bromfield then laconically remarked, "Some few altercations as to our private opinions on that subject follow'd." Aylett was concerned that his many enemies would talk and the Masters of Eton School might think meanly of a man who was not equal to an operation of that kind but had to send for a *London man.*[13]

Aylett was undoubtedly responding to the eighteenth-century rivalry between city and country practitioners. Especially in London, surgeons were using the new hospitals and private medical schools to build a power base for themselves as their professional body, the Company of Surgeons, fell into a relative decline. In addition, they had considerable patronage through obtaining court positions. For example, from 1744 Bromfield was a well-paid full surgeon at the new and fashionable hospital of St. George's. In 1747 he paid 350 pounds to purchase land near Hyde Park Corner for the construction of a charitable institution, Lock Hospital, for women and children suffering from the "secret malady" or syphilis.[14] He was also a respected anatomist and after 1743 gave a yearly course of forty lectures in anatomy, physiology, surgery, pathology, and midwifery to pupils at Guy's Hospital at the cost of ten guineas per head. He published two volumes of *Chirurgical Observations and Cases* in 1773 and rose through the Royal Court's ranks from extraordinary to ordinary surgeon to the Princess Dowager of Wales. When Bromfield died in 1792, John Hunter bought all of his specimens and preparations for 150 pounds and placed them in his anatomical museum.[15]

The superiority of hospital surgeons who "see more in one Year than they could otherwise do perhaps in the whole Course of their Lives" as a country practitioner was acknowledged by patients.[16] Indeed, after finding out that it was the rustic Aylett rather than the cosmopolitan Bromfield who had sawed through his leg bone, Mr. Benwell addressed a scathing letter to the former. He demanded to know how, given Aylett had urged Bromfield on him, he could be vain enough to suppose that an operation of that kind "can be so

---

[13]Ibid., p. 9.

[14]For details of Bromfield's career, see Susan Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press, 1996) and Linda Merians, "The London Lock Hospital and the Lock Asylum for Women," in Linda Merians, ed., *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France* (Louisville: University Press of Kentucky, 1996), pp. 128–145.

[15]See Lawrence and Merians as cited in footnote 14.

[16]Lorenz Heister, *A General System of Surgery* (London, 1740), p. 13.

well performed by any country practitioner, who may not do it, five times in his whole life; as one who is under a necessity of doing it in a hospital, probably as many times in a week."[17]

With increasing frequency during the course of the eighteenth century, country surgeon-apothecaries, such as George Aylett, were satirized as shabby poor figures who, "with a rusty wig, dirty boots, and leather breeches, degenerate into a hum-drum doctor, ask common-place questions by rote, their merits not diffused beyond a country chronicle, and their fame confined to a country church yard."[18]

In their turn, London hospital surgeons were caricatured as aloof, foppish in dress, eager for publicity, keen to attach their name to a remedy or surgical device, and, like quacks, more concerned with the guinea than the patient.[19] Aylett was to write that "my education has been at least as liberal as Bromfeild's (sic), I have practiced near as long, and am of good reputation," tartly adding, "I profess not to have any *Nostrums*, nor ever thought of making a *ligature upon the Aorta, for the cure of an aneurism*"—an allusion to two of Bromfield's publications.[20]

The outcome of the dispute over who was to actually perform the amputation was a muddled compromise. Having failed to tell Aylett that the patient and Mr. Howard had already asked him to undertake the amputation, Bromfield went upstairs. There he reportedly told the patient Mr. Benwell, and the standard audience of concerned friends around his bed, that Aylett and Howard were competent surgeons and if they did not perform this operation then "it might lessen them in the esteem of families in their neighbourhood."[21] To this the longsuffering patient replied that he did not see this at all and he wanted Bromfield to take his leg off now.

---

[17]Bromfield, p. 39.

[18]*A Sketch of the Life and Character of the late Dr. Monsey* (London, 1789), p. 15. According to his anonymous biographer, Monsey was born in 1693 in Norfolk, educated at Oxford, and was only rescued from a life of drudgery as a country doctor in Bury when he saved the life of Lord Godolphin, who then became his patron in London. He eventually became chief surgeon at the Chelsea Hospital and a Fellow of the Royal Society.

[19]See in particular Lawrence, *Charitable Knowledge*, Part II.

[20]Aylett, p. 22.

[21]Ibid., p. 10.

Informed of this, Aylett rushed upstairs again, and "returning momentarily told Bromfield that the patient had desired us to settle it amongst ourselves."[22] What this amounted to was that

> Aylett said he should be glad to cut thro' the integuements and muscles; that I should divide the flesh between the bones, and remove the periosteum, that he should saw thro' the bones; and that I should secure the blood vessels; which, says he, every one knows is the principal part of the operation. All this was agreed upon.[23]

A mere three weeks after Bromfield published his account of the dispute, George Aylett responded with *A Genuine State of A Case in Surgery: Being a Full Refutation Of Certain particular Facts related by Mr. Bromfield.* Priced at a mere sixpence, his thirty-six page pamphlet appealed not to the patient but to the surgeons' professional body, the Court of Assistants and the Company of Surgeons in London, to adjudicate the dispute. Aylett wanted his words to provide that tribunal with a plain account regarding the malicious slanders of Bromfield regarding his character and conduct. In Aylett's opinion,

> this narrative, which he exhibits as a justification of his own character, is in fact a virulent attack upon mine, as it implies a complicated charge against me, of insolence, barbarity, and ingratitude![24]

Of course, Aylett's description of the events surrounding the amputation of Mr. Benwell's leg was quite different from Bromfield's. Having assumed "as once before" that Howard would not do the operation, he had prepared his instruments. Thinking of Bromfield as only a consulting surgeon, he had been outraged to find him dressed to perform the amputation for, as the other *first* surgeon, Aylett should have been given the task by Howard. Not having "implicit confidence" in Bromfield at this point, Aylett went to see the patient for himself. While it was true, he said, that Mr. Benwell had *at first* said that he wanted Bromfield to take his leg off, his close friend Mr. Poppleton had cautioned the patient to consider

---

[22]Ibid., p. 12.
[23]Ibid., p. 12.
[24]Ibid., p. 2.

that "these gentlemen are both able men; we don't understand their forms of business, 'tis better to leave this affair to be settled by themselves."[25] With this, Mr. Benwell had finally agreed and returning downstairs Aylett had told Bromfield of the patient's wishes, graciously offering that

> While I have an undoubted right to insist on performing the whole operation but as matters were circumstanced, I would take off the limb, and he should take up the blood vessels: adding, (but not with a design to pay him any real compliment, as he would insinuate), that *under his auspices,* I surely could not fail to perform the operation properly.[26]

We must ask what ethical advice was available to eighteenth-century surgeons in undertaking a joint consultation with a patient? There was little conception of the medical profession as a comprehensive entity or even as a collective abstraction. Individual, face-to-face clinical encounters tipped the balance between distrust and confidence.[27] Advice concerning the demeanor of a surgeon towards his patients had been published as part of general medical works since the fourteenth century and long sections described the ideal character of a surgeon.[28] In 1739 the London surgeon and physician Daniel Turner began his directions to future medical men with "do not with Grimace break some sorry Jest at the Bedside, as I have been Witness of . . ." and continued with advice upon dress and the correct emotional stance:

> It will behove him to appear always neat in his Attire, avoiding the Extremes of the Fop and the Sloven, with a chearful Countenance, especially before the Sick; rather compassionating their Infirmities, than resenting every little Excursion which Pain and Peevishness may extort from some of them. . . .[29]

Patients were essentially to be treated as overemotional children—of necessity they must be indulged—and yet it was also crucial that they completely submitted to the authority of a good

---

[25]Ibid., p. 5.
[26]Ibid., p. 6.
[27]Porter, *Patient's Progress*, p. 69.
[28]For examples, see Thomas Gale, *An Institution of a Chirugion* (London, 1563), or William Bullein, *Bullein's Bulwarke of Defence Againste all Sickness, Sores, and Wounds* (London, 1562).
[29]Daniel Turner, *A Discourse Concerning Fevers* (London, 1739), p. 328.

surgeon, as a child should to a good father. In his 1803 work, *Medical Ethics*, Thomas Percival reinforced this picture of the patient as the sum of his erroneous sentiments:

> . . . human nature must be intimately studied, to acquire that full ascendancy over the prejudices, the caprices, and the passions of the sick, and of their relatives, which is essential to medical success.[30]

However, Enlightenment English surgeons did not simply rely on recreating paternal authority at the bedside in order to gain clinical control. They were also fond of quoting the first-century Roman encyclopedist Celsus as their guide to ethical behavior. In arguably the most popular work on surgery in mid-eighteenth-century England, Lorenz Heister (1683–1758), professor of anatomy and surgery at Helmstedt, wrote:

> As the great Celsus advised, If the Surgeon shall find the Disorder to be of such a Nature as to require the Knife, he should declare this in due time to the Patient, and should have Consent before he undertakes it.[31]

In short, patients requiring surgery offered the prestige of a cure but also the threat of failure and so became objects of both value and scorn. They were to be cosseted but kept under control. The quandary Aylett and Bromfield found themselves in was because they had failed to follow the advice of Celsus in obtaining a full consent from the patient. This muddied everything that came afterwards.

II. The Amputation and the Aftercare

Surgery was hazardous and therefore greatly feared during the eighteenth century. Indeed, amputation secondary to a compound fracture (a common horse-riding accident) often resulted in death from blood loss or sepsis. Considerable pain and anxiety were also involved in such procedures both at the time of the surgery and especially afterwards.

---

[30]Thomas Percival, *Medical Ethics or A Code of Institutes and Precepts Adapted to the Professional Conduct of Physicians and Surgeons* (Manchester, 1803), p. 24.
[31]Heister, *A General System*, p. 15.

> The dressings, which have now formed a considerable adhesion to the whole surface of the wound, and the separating them from the extremities of the nerves, is the more painful, than any part of an amputation . . . [32]

Celsus had cautioned surgeons to make their preparations out of sight of the patient, as he or she might faint with fear, and to keep spectators at a minimum, as they disturbed the patient and the operator by blocking out light and rudely pressing upon them. To gain credit with the bystanders, the patient was to be encouraged by promising to treat him as quickly and tenderly as possible. However, contemporary surgeons also quoted Celsus on the emotional detachment necessary in operating:

> . . . cures which are to be performed by the Hand, especially those which are attended with great danger and cruelty in the execution of them, require a singular hardiness of temper and resolution of mind; or, as that *Cicero* of the *Physicians*, *Celsus*, speaks, "An intrepid mind void of all tenderness and pity, and entirely deaf to the Shrieks and Outcries of the suffering Patients: Which is to be met with in very few. . . [33]

Neither Aylett nor Bromfield lingered over the details of the "friendly" amputation itself, except to relate it was quickly done and the patient did not inconvenience them much with his cries. However, immediately after the operation Aylett protested because Bromfield gave the patient an anodyne draught without first revealing its ingredients, and *both* men left their apprentices to watch over the patient along with the arduous task of applying constant pressure to the stump for the next twelve to sixteen hours. Indeed, Mr. Benwell was not expected to make it through the first night, as his muscles were badly swollen and infected before the operation and, moreover, he was "full of habit."[34]

Yet survive he did, and two days later Bromfield returned from London to dress the stump. Aylett failed to appear until the very end of the dressing change, complaining they had not summoned him in time. Naturally, Bromfield responded that Aylett had ignored his repeated invitations to be present.

---

[32]Edward Alanson, *Chirugical Observations* (London, 1742), p. 80.
[33]Heister, p. 3.
[34]Bromfield, p. 13. "Full of habit" referred to Mr. Benwell's corpulent frame.

In the meantime the patient gave expression to his needs:

> Mr. Benwell [had] said he did not care whether Aylett came or not: "*he then insisted on being immediately dress'd as he was in great pain, and lay very wet from the discharge*"; which was likewise extremely offensive; it being very hot weather, and the pillow hard and dry.[35]

In fact, it was a major breach of surgical ethics for Bromfield to dress the stump without the other operating surgeon being there, and he quickly turned to justifying his decision on the grounds of patient welfare:

> I thought it more prudent to break thro' a punctilio in our general form, and do what might have been thought irregular amongst strangers, than to risque the consequences of Mr. Benwell's hurrying himself more.[36]

Aylett's late arrival at the first stump dressing appears to have been the final straw for the patient, for in front of the tardy Aylett he requested that Bromfield alone dress him in the future. To this formal dismissal Aylett responded with an escalating campaign of grievances. First, the two surgeons took a private but noisy turn around the garden. There Aylett accused Bromfield of wrongly accepting Howard's request to be Benwell's surgeon, giving a medication without revealing its ingredients, and now he had done the first dressing without him and so conspired to get him discharged by the patient.

Second, after a series of letters back and forth, with Bromfield writing no intentional harm was intended and Aylett calling him nasty names, they finally agreed to meet in a public space. This was to be a local tavern where the case could be judged in the presence of witnesses who would ask Bromfield to extend his pardon to Aylett if necessary.[37] As the two men lined up for this verbal duel to establish the truth of their clinical encounters, they chose seconds. Bromfield brought along the nearest relative of Mr. Benwell, thus displaying his control over the patient, while Aylett brought a local physician and a vicar, implying that he had both the medical profession and God on his side. Bromfield finally admitted that he was

---

[35]Bromfield, p. 14.
[36]Ibid., p. 15.
[37]Aylett, p. 19.

wrong "tho' without design," in treating Aylett so irregularly, and as Aylett gleefully related, "the witnesses there heard the articles of impeachment read to him and he acknowledged each separately and asked my pardon viva voce, and then signed his name to his own condemnation."[38]

In his book, Bromfield defended his signing by claiming he did it out of great friendship for Aylett and perhaps because he had been intimidated by him. To these charges Aylett responded that Bromfield had never shown such great bias to friendship before. Moreover, his mixed motives were "a striking instance of his effrontery, and a plain proof, what degree of reliance may be had on the other part of Mr. Bromfeild's narrative."[39]

Bromfield returned to St. George's Hospital, only to discover to his horror that letters were now being

> sent all over *London,* and copies of the paper sign'd by me, *with additions,* transmitted to every coffee-house and ale-house in town and country, by agents employ'd for that purpose.[40]

He supposed that Aylett, having satisfied his "chirurgical honour" at the tavern, could only be doing such a thing to deflect the attention of those to whom Mr. Benwell's friends had complained of his inhumanity in contesting who did the operation as the patient lay in anxiety and pain. Aylett countered that Bromfield

> designed to snatch the patient out of my hands: that in the execution of this design, he tampered with the passive disposition of the other surgeon concerned, and endeavoured to overawe me into a tame acquiescence, or provoke me by ill usage to retire in disgust. It appears, I hope, that in this whole transaction I acted the part of a man who had sense enough to feel, and spirit enough to resent an injury.[41]

It was unusual that the final salvo in this medical dispute was fired by the patient himself. Mr. Benwell published a pamphlet in 1760 as *A letter to Mr. George Aylett* where he accused the country surgeon-apothecary of overriding his wishes, being cruel and incompetent, and a liar and a barbarian. Moreover, he had yet to recover from the operation and indeed would have probably died if

---

[38]Ibid., p. 20.
[39]Ibid., p. 20.
[40]Bromfield, p. 21.
[41]Aylett, p. 22.

the news had not been kept from him for three weeks that it was actually Aylett who had sawed through his leg and not Mr. Bromfield, as he believed.

Needless to say, Aylett responded to these charges in *A Full Reply to a Letter under the name of Joseph Benwell of Eton* (the title obviously implying that he believed Bromfield had actually written Benwell's pamphlet). Aylett accused the patient of being ungrateful and not really ill—he claimed that Benwell had been seen traveling through two or three counties hawking his pamphlets at horse races in order to blacken Aylett's reputation.

He blamed Benwell's accusations on the fact that he had caught a fever shortly after the operation and

> while he was fretted with pain and rendered peevish by distemper; it is natural to suppose he would complain, and even hint a suspicion of his having been treated amiss. The emissaries (meaning the apprentices) of Mr. Bromfield who continued to live in Benwell's house must have seized this opportunity of telling him in plain terms that the bad symptoms arose from me taking his leg off rather than Bromfeild (sic). This could hardly fail of producing A DEEP FUND OF HATRED AND RESENTMENT.[42]

Essentially, Mr. Benwell was out of his wits and not to be listened to.

III. Conclusions

In this preliminary survey, I have analyzed Aylett's and Bromfield's detailed accounts of their increasingly acrimonious encounters—at the patient's bedside, in private rooms and gardens, and in "neutral" public spaces such as inns—to draw general conclusions regarding the role of trust and mistrust in eighteenth-century clinical encounters.

I have suggested that the mid-eighteenth century saw surgeons following, and frequently breaking, both ancient ethical guidelines and contemporary rules of gentlemanly conduct, the former being more important than the latter in Aylett and Bromfield's disagreement. In short, the dispute between Aylett and Bromfield did center on behavior appropriate to medical men rather than *every man*.

---

[42]Aylett, *A Full Reply*, p. 33. Capitalization by Aylett.

The unique experiences of practicing surgeons influenced the images they fashioned for themselves and projected onto their patients and peers. Bromfield saw Aylett as a rude country bumpkin, whereas Aylett saw Bromfield as a slippery London fake. In turn, Bromfield saw the patient as a lucrative patient while Aylett saw him as a dull-witted child.

A number of conflicting agendas created the disagreement between Bromfield, Benwell, and Aylett. While the patient had an urgent need and information regarding his injuries, the surgeon had the expertise and so the authority to heal them. Far from patient and surgeon sharing a common discourse, once the surgeons gained access to the bedside they used any means to maintain control. This included lying to the patient and developing selective hearing when in his presence and that of his friends. They castigated one another's shortcomings before credible witnesses and employed agents publicly to disseminate information about their rival's unprofessional behavior to local coffee- and ale-houses. Finally, the decision to publicize a disagreement between medical practitioners rested on whether the rumors had spread beyond the local area and, above all, if they had reached the ears of rival surgeons.

Not surprisingly, when Gregory and Percival published their codes of ethics for medical men in the late eighteenth century, they made much of the necessity to conduct disputes privately and in a dignified manner, keeping only the interest of the profession in mind, rather than acting out of foolish pride and the self-interest of a mere tradesman.

"The foul altar of a dissecting table": Anatomy, Sex, and Sensationalist Fiction in Mid-Nineteenth-Century America

Michael Sappol

In an 1851 homily entitled "A Little Plain Talk for the People," published in the *American Journal of Medical Reform*, Dr. Frank Stewart identified the set of people who stood in need of instruction in anatomy and physiology. These were a vice-ridden "class of readers," young men who were "ignorant of the construction of their own bodies . . . and who generally compose the mass of sufferers."[1] Resistant to anatomical teachings, such readers were distracted by, even addicted to, an entirely different set of texts:

> [T]housands of yellow-covered emissaries of Satan . . . known as cheap novels, are sold in [New York City] each month, eagerly bought up by the young; not a steam-boat can be approached, or a railway station reached, but that the ever watchful news-boy appears, and tenders with the one hand the extra containing the latest news from California or Europe; and with the other the yellow-covered novel for only twenty-five cents or less, the latest emission of some wicked imagination on its way to debase the young men and women of this land. . . .
>
> Enter our rail-road cars—visit our steam-boats—go, if you please, into any of our large hotels—and there . . . can be seen some young man lounging on the sofa, eagerly drinking in this polluting poison until he is lost to all that is going on around him. A habit once formed for this kind of reading, appealing, as it does to the "animal man," the baser appetites, the reader eagerly craves more, until the spare time at home or behind his employer's counter is spent daily, nightly, in this to him, fascinating amusement . . . .[2]

---

[1]*American Journal of Medical Reform* 1.1 (1851): pp. 1–2.
[2]Ibid., p. 2.

Stewart's piece sets the context in which temperance, moral reform, and instruction in anatomy and physiology became compelling to a new mass audience: a sprawling urban environment of cities and towns, with boarding houses, hotels, playhouses, and other commercial establishments, connected by a web of rivers, canals, railways, and roads, where entrepreneurs incessantly hawked an ever-multiplying array of pleasures. This was a new, morally unpoliced sphere of consumption that continually subverted the discipline necessary to shape and regulate the bourgeois self. In Stewart's vision, "medical reform"—which is tantamount to moral reform and, more broadly, bourgeois self-formation—requires teaching anatomy and physiology to the "*mass* ignorant." "Animal man" must learn that violation of the "immutable laws" that govern the body has dire consequences: illness, disfigurement, social debarment, sexual debility.

Stewart assumed that the physiologically-minded made up a class apart from the devotees of yellow-covered novels. We may not be so sure. Diary entries show that Samuel Edgerly, a young New York City merchant's clerk working "behind his employer's counter," read serial fiction, reveled in minstrel shows and the circus, but also went to church regularly, heard morally instructive lectures and sermons, and took a tour of the dissecting rooms of the College of Physicians and Surgeons.[3] Stewart's *American Journal of Medical Reform* (and similar contemporary publications) attracted a middling audience of readers, both rural and urban, some of whom may very well have succumbed to the pleasures of sensationalist novels, cheap romances, and joke books—even as they sought to define themselves in anatomical and physiological terms as "temperate," "genteel," "healthy," "respectable," "civilized," "cultivated," "educated," "moral," "virtuous," "intelligent," "hygienic"—the terms that collectively signified bourgeois identity. And, if some of Stewart's readers abstained from the proliferating pages of yellow-covered novels, they were more than matched by a large reading public that was bored by popular anatomy's lack of narrative impulse, its condescending tone, and its joyless insistence on proper behavior.

The sheer number of popular anatomy texts published, popular anatomical exhibitions staged in respectable physiological societies and entertainment-oriented museums and circuses, and the enthusi-

---

[3]Samuel A. Edgerly, New York City, diary, 1859–1860 [New York Public Library].

astic reception accorded popular anatomical lecturers like John M. Wieting and F.C. Hollick, shows that the anatomical body was important to a wide swath of the American public during the last three quarters of the nineteenth century. This importance was not quite the same thing as approval or disapproval. Medical professionals, reformers, middle-class men and women, the indigent poor, all had different stakes in the new cultural politics of the body. Anatomy was one of many cultural goods circulating in mid-nineteenth-century America. And if anatomy overflowed the banks of professional medical discourse, it also overflowed the banks of popular medical discourse and entered the realm of fiction, poetry, fine art, cartoons, almanacs, political rhetoric, and so on. Here it sometimes received a less than respectful reception, as in this line from a postbellum jokebook: "Brown, while looking at a skeleton of the jackass, remarked, that 'we are fearfully and wonderfully made.' "[4]

In this essay, it will become apparent that yellow-backed novels were also not innocent of anatomy. As the anatomical body began to become a prerequisite of bourgeois identity, as anatomy became identified with the body, it came into contact with the discourse of flesh, desire, and corruption that was articulated in Christian theology, political rhetoric, and folk narratives, but also in the blackface minstrel show, sensationalist fiction, and melodrama. Anatomical claims to epistemological authority, established through graphic representation, latinate nomenclature, dissection performances, and narratives, made anatomy an appealing product in the marketplace of cultural goods. Willy nilly, anatomy also provided a powerful discursive resource for other cultural practices—hostile, ambivalent, indifferent, or supportive.

Popular anatomy and the sensationalist novel had roughly parallel trajectories. In the 1840s and 1850s both found the mass audience that formed in association with new print and transportation technologies, and that clustered in cities and towns. Given their close proximity, it is not surprising that anatomy should make its way into the sensationalist novel. The physician was a regular member of the cast of representative characters who populated the pages of sensationalist fiction. More often than not, he appeared as a dissector, a powerful figure (or someone desiring to be so) whose authority was asserted in the graveyard, the anatomical theater, the anatomical museum, and on the dissecting table, on the bodies of

---

[4]S.W. Clark, *From the Ridiculous to the Sublime* (Chicago, 1875), p. 31.

the living and the dead. In real life, as in the sensationalist novel, the anatomist operated at the center of a proliferating social network that connected well-to-do patients, colleagues, striving medical students, proletarian body snatchers, and cadavers. The anatomist's power had a sexual and social valence. It emerged and operated through a matrix of meaning in which social honor and class identity—and sexual honor and gender identity—were intertwined. Anatomy was gendered: dissectors were male, the dissected were discursively female. Anatomy was class-based: the medical gentry dissected; the poor were dissected. Antebellum sensationalist novels exploited these metaphorical elements by obsessively fixing on the acts of dissection and body snatching, and on the dyad of the anatomist and the dead body, especially the dead female body.[5]

Edgar Allan Poe proclaimed that "the death of a beautiful woman is . . . unquestionably the most poetical topic in the world."[6] The two sensationalist novels discussed below—John Hovey Robinson's *Marietta, or the Two Students: A Tale of the Dissecting Room and "Body Snatching"* (1846) and George Lippard's *The Quaker City, or the Monks of Monk Hall* (1845)—follow this dictum and improve on it.[7] Set in the night-time world of the antebellum city, a world of unbridgeable social and gender divisions, they are necrophiliac "narratives of sexual danger."[8] Beautiful young virgins, living and

---

[5]This is not to say that mid-nineteenth-century fiction only portrayed doctors negatively. In *Hawthorne's Mad Scientist: Pseudoscience and Social Science in Nineteenth-Century Life and Letters* (Hamden, CT: Archon Books, 1978), p. 118, Taylor Stoehr argues that it "tended, if anything, to idealize the physician, concentrating on his eligibility as a husband for spirited but impoverished heroines." And yet, Stoehr reminds us, Hawthorne's fiction is full of memorable mad scientist-physicians—Rappacini, Chillingworth, Maule, Westervelt, and Aylmer—though none is precisely an anatomist. William Leach, *True Love and Perfect Union: The Feminist Reform of Sex and Society* (New York: Basic Books, 1980), p. 172, cites Caroline Dall's 1871 comment that "the heroes of most books are physicians" [Dall journal, 8-16-1871, Massachusetts Historical Society] and gives a list of 1860s and 1870s novels with physician-heroes: Marie Howland, *Papa's Own Girl*; Henry Ward Beecher, *Norwood*; Caroline Corbin, *A Woman's Secret*; Mary Clemmer Ames, *Eirene; or A Woman's Right*; Diana Murdock, *Life for a Life*; May Braddon, *The Doctor's Wife*; Lillie D. Blake, *Fettered for Life*; Andrew Jackson Davis, *Tale of a Physician*.

[6]"The Philosophy of Composition" (1846), qtd. in Elisabeth Bronfen, *Over Her Dead Body: Death, Femininity, and the Aesthetic* (New York: Routledge, 1992).

[7]J[ohn] H[ovey] Robinson, *Marietta, or the Two Students: A Tale of the Dissecting Room and Body Snatching* (Boston, 1846); George Lippard, *The Quaker City; or the Monks of Monk Hall* (Philadelphia, 1845).

[8]The phrase "narrative of sexual danger" comes from Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992).

dead, are preyed upon by brutish body snatchers, aristocratic seducers, demonic sorcerors, or scientific experimenters. Mad doctors hypnotize or drug young women into death trances in order to dissect or debauch them. Dark conspiracies abound: virginity constantly suffers the threat of rape or betrayal; and the deflowered virgin suffers an irreparable stain, an ineradicable and contaminating moral pollution that, as we shall see, was connected to anatomical dissection.

1. Anatomical sensationalism: *Marietta*

Virtually unknown today, John Hovey Robinson (1825–1867) was a moderately successful hack novelist, who over several decades churned out westerns, medieval romances, historical fiction, and mysteries.[9] Before becoming a writer, he briefly attended Harvard Medical College. *Marietta*, his first novel, is set in a seedy area of Boston in 1842 and shows some familiarity with the workings of the anatomy room. The hero is Levator, a name which suggests he is morally elevated, but also a man of action; *levator* is an anatomical term for a muscle that raises a body part. In the first scene, some body snatchers provide him with a cadaver, the body of a beautiful woman. In a long soliloquy, he agonizes over whether to dissect her: "How can I disfigure that angelic face, how can I cut, piecemeal, the flesh from those delicate limbs, and observe daily the ravages of the scalpel . . . converting it in that corse into all that is loathesome" [*Marietta*, p. 3]. Levator has fallen in love with his anatomical subject. In the midst of his reverie he is interrupted by his charismatic professor, Dr. Frene, whose name is the Greek word for brain (suggesting that he represents pure reason unencumbered by moral restraint). Dr. Frene is accompanied by Eugene, a well-born but dissipated medical student. Frene asks Levator if he has begun the dissection. Levator replies: no, he cannot, will not. Eugene then brandishes a scalpel and announces that if Levator does not dissect,

---

[9]Robinson, occasionally credited on his title pages as an M.D., was the author of at least thirty novels, many of them reissued after his death by the dime novel publishing house of Beadle & Adams. *Silver-Knife, or the Hunter of the Rocky Mountains; A Romance of the Wild West* (Boston, 1850) incorporates a short anatomical narrative. Around a campfire, the hero tells the story of his hurried departure from an Eastern city after being caught in a body-snatching scandal as a young medical student.

he will, beginning with the face "in order that it may not be recognized . . . by any of the friends of the deceased" [*Marietta*, p. 5]. Levator, horrified, interposes himself between Eugene and the body; a heated argument ensues. Frene reproaches Levator for his illogic and "sensibility" (oversensitivity, a noble, but feminine trait), and questions his courage:

> . . . you carry your sensibility too far. What possible harm can it do that body—fair and delicate it is, I allow—to dissect it? Will it feel the keen edge of the knife? Will the tender limbs shrink from it, and give intimations of torture? Do you fear that those closed eyes there, will start open, and that clod-like hand will raise itself, and that still tongue will throw off the spell of death, at the first incision, and entreat you to desist? Fie! where is your manhood? [*Marietta*, p. 6]

Frene equates the mastery of the dead body, the display of clinical detachment in the dissecting room, the will to dissect, with masculinity. Levator, accepting the premise, defends himself:

> Have you not seen me without anything like fear or hesitation, look upon death in all its awful phases in the form of wrinkled old age, smiling infancy, and at every point between . . . ? Have I not seen it in every stage of decomposition, and in all its loathsome details? Have you not seen me sever joint from joint, and muscle from muscle a score of times, without the least symtoms [sic] of emotion? [*Marietta*, p. 6]

Frene concedes the point but not the larger argument, offering a final rebuke: "I have often thought that I never knew a student so indifferent to the 'disagreeables' of a dissecting-room as yourself; but to-night you are a *woman*." [*Marietta*, p. 6]

The anatomical plot and iconic conventions of medical identity easily lend themselves to the purposes of sensationalist fiction. More than a style, sensationalism is a set of textual procedures designed to produce effects on the reader's body; sensationalist prose incites bodily sensation. "Philosophical" fiction, history, and other "high" genres, in contrast, "elevate" the reader's mind (or spirit or soul).[10]

---

[10]But sensationalist fiction does share certain narrative and rhetorical elements with "philosophical" fiction (see, for example, Hawthorne). Any genre, if its tone was "high-minded" and prose "artful," might make credible claims to have morally beneficial effects (and virtually every work of fiction, even the crudest dime novel, made such claims). The intended audience, style, quality of paper, binding and illustrations, etc., determined whether such claims had credibility, whether a romance was consigned to high or low literature.

(Sentimental fiction, an intermediate form, does both; it moves the reader bodily to sympathetic tears, but tears are morally redemptive.) Sensationalist fiction is not quite pornography, but has affinities to porn; it works on the body of the reader through representations of the body in the text. Robinson teases the reader: much of his first chapter is conducted over the body of a naked woman; there are repeated references to tender limbs, fair skin, etc., always in conjunction with a feinting movement of the scalpel. Robinson stands the Petrarchan convention of literary dismemberment on its head, in effect; the scene is a perverse dissecting-room parody of the poet's inventory of parts of the beloved.[11] Sensationalist fiction attracted a largely male readership, and typically used masculinist tropes. The act of penetrating the dead body with a sharp knife is a masculine performance: fear of death and the dead body is feminizing; the man who cannot master his fear is "unmanned"; the woman who does not fear death or the decomposing dead body is "desexed," masculinized.

The dissecting room is a liminal zone where doctors and students cross the boundary between life and death, between the exterior and interior of the body, and are initiated into an exclusive homosocial order. Members of homosocial bands typically claim special exemption from rigorously enforced social strictures. Already marked as privileged gentlemen by their elevated diction, upright posture, and fine clothes, the shared experience of dissection (signifying the ability to master the dead body through reason and force of will) binds the medical students together and marks them as a distinctive fraternity of dissectors. Levator's refusal to dissect undermines his place within the fraternity, disrupts the group. Behind his refusal lies a more fundamentally disruptive power, the erotic power of a sexually desirable woman (in this case a dead woman!). Eve Kosofsky Sedgwick has argued that male homosociality defines itself in opposition to the feminine, and is part of a continuum that sometimes includes homosexuality, even as it works to enforce the heterosexist order, and a shared traffic in women (and here also a shared traffic in cadavers).[12] Scornfully dismissed as a "woman" for

---

[11]See Bette London, "Mary Shelley, *Frankenstein*, and the Spectacle of Masculinity," *Publications of the Modern Language Association of America* 108.2 (1993): pp. 263–64, which shows that Mary Shelley parodized Petrarch in cataloguing the monster's "beauties." A more explicit parody can be found in the penultimate section of Francis Hopkinson's *An Oration which might have been Delivered to the Students in Anatomy* . . . (Philadelphia, 1789), which takes the form of a love poem to "Brown Cadavera."

[12]Eve Kosofsky Sedgwick, *Between Men: English Literature and Male Homosocial Desire* (New York: Columbia University Press, 1985), pp. 1–2.

his refusal to dissect, Levator playfully takes up the conceit, replying that, if so, then Frene, a ladies man, would accede to his wishes, in order to seduce him. But joking fails to restore homosocial solidarity. "[T]hat body," Levator insists, "shall not be mutilated with a dissecting knife"; Frene and Eugene are forced to withdraw, unsatisfied. Left to himself, Levator resolves to hire the body snatchers to return the body, to "place it safely in the tomb . . . where it may crumble and mingle peacefully, and in obedience to natural laws with its kindred atoms" [*Marietta*, p. 9]. The thought consoles him: the dematerializing dispersion into nothingness counters the horrifying prospect that his beloved's body will be rendered hideous by decay. He takes a ring off the finger of the dead woman, and exchanges it with a ring from his own hand, a symbolic betrothal.

He then travels under cover of night to another liminal zone, a filthy, decrepit waterfront tenement apartment, a dismal place that is the antithesis of the bourgeois home (there are "no chairs . . . the deficiency supplied by a rude bench and blocks. . . . You are looking for a table: there is none"). There he finds the two body snatchers who originally supplied the beautiful corpse: Gaunt, "a skeleton . . . invested with a scant covering of skin," "a wreck of a human being," and Thick, his muscle-bound, libidinous, bullying partner [*Marietta*, p. 10]. For thirty dollars (a hefty sum in 1846), Levator purchases another body to dissect and, with a barrage of insults and threats, directs the two men to return the cadaver to the grave from which it was plundered.

The scene next shifts to the apartment next door, a bordello where Eugene's mistress, Cecil, lives: "several wretched beds are seen in different parts of the house. . . . One must be very tired and sleepy to rest upon such couches; and let us go farther and say that no one ever did or ever will rest upon such as these" [*Marietta*, p. 12]. Cecil is a fallen woman, and also the object of Thick's unwelcome advances. Beset by terrible nightmares, she awakes and discovers the body snatchers' "dead room," which is visible through a crack in the wall. There on a slab lies the decomposing body of her first seducer, the man who destroyed her sexual honor, now dead of advanced syphilis, a medico-moral punishment for debauchery.

Meanwhile, the body snatchers scheme to sell Levator's beautiful corpse to some other buyer, so as to make triple rather than double money—and rid themselves of the work and risk of restoring it to its burial place. Carrying the body in a sack, they encounter Dr. Frene and Eugene; a deal is quickly consummated. Without examining the goods, the professor and student decide to experiment on

the subject with a "Galvanic battery," to study "the wonderful power of electricity on the dead body." Such experiments, which were sporadically conducted in the first four decades of the nineteenth century, served as a kind of medical performance art, a demonstration of the physician-anatomist's ability to manipulate the *elan vital*, even to resurrect the dead. Opening the sack, Eugene and Frene discover that they have purchased Levator's subject. Frene gloats that now they will have their way. The erotic coding of the scene is unmistakable: "[T]hat corpse—in all its unearthly beauty is about to be offered for the advancement of science. . . . 'Make a very small incision, Eugene, just back of the ear. . . . Now place the conductor in the orifice'" [*Marietta*, p. 30]. However, with successively stiffer jolts, the dead woman revives. She has not really been dead, or has she?

The tale continues on, but the only extant version of the serialized novel stops a few pages later, in the middle of the story. A 1945 article by F.C. Waite provides a synopsis of the full novel and tells the finish: the revived woman is restored to health and returns to her family, with no knowledge of what has transpired while she was in her death-trance. Some months later she encounters Levator, who shows her the ring on his finger and explains matters. They marry and live happily ever after. Waite, however, does not explain who or what caused the heroine to fall into the death-trance and be prematurely buried.[13] In J.V. Huntington's longer and more literary *Rosemary, or Life and Death*, an 1860 novel which uses many of the same plot elements, the beautiful woman has been drugged by a mad anatomist.[14]

The body snatchers in *Marietta* represent the lowest depths of society. Socially dead, outside the moral order, they are animalistic brutes, insensitive to death's moral consequences, numb to the aesthetics of beauty and the sublimity of death. The medical students represent the upper class; they constitute the social order. But within the liminal zones of the dissecting room, the derelict waterfront district, and the nighttime city, their membership in the fraternity of dissectors exempts them from the moral discipline and manners required of their class. In these inter-zones they consort

---

[13]Frederick Clayton Waite, "Grave Robbing in New England," *Bulletin of the Medical Library Association* 33 (1945): pp. 290–91, 294, nn. 38–39. Waite found a similar tale in G.T. Ridlon, Sr., *Saco Valley Settlements and Families, Historical, Biographical, Traditional, and Legendary* (Portland, ME, 1895), pp. 387–88.

[14]J[edediah] Vincent Huntington, *Rosemary, or Life and Death* (New York, 1860).

with those outside the social order, the physically and socially dead. And in such spaces, they are not always genteel. In the dissecting room, the female anatomical subject is "rudely gazed upon, by the curious eye" of the dissector. Distressed at the prospect of the "rough touch of the student at work on the limbs of his beloved corpse," Levator resolves that "the coarse jest of the thoughtless and unfeeling shall never be uttered over it, or fall . . . upon these dead ears!" [*Marietta*, p. 9]. Rationalist discourse undermines any "spiritual" valuation of the dead body and licenses a certain homosocial vulgarity.

The division between upper and lower classes corresponds to the binary self: upper-class mind versus the lower-class body. (Body has two aspects: Thick represents the sexual/animal body; Gaunt represents death, the body minus spirit.) But the body/mind dichotomy is disrupted by a third term, "spirit," represented by Levator and Marietta. Spirit (disembodied love) is the highest moral category; the disinterested spiritual fusing of masculine and feminine is morally redemptive. Reason (Frene) and aestheticism (Eugene) are associated with the moral depravity of the body. They are coded as masculine qualities, which too easily descend into self-interested dissipation and hubris (aristocratic vices). Their proximity to the body side of the ledger is dangerous; they are tainted with embodied desire.

Marietta also has a feminine symbolic: the woman-is-body topos, an ancient trope.[15] Cecil, the fallen beauty, represents the contaminated sexual body (Eugene fornicates with her; Thick wants to rape her). Marietta, the dead beauty, represents the virginal body, frozen in its purity by death, made over into a representation. The virgin, the unpenetrated object of desire, has a transcendent value, can only be exchanged once, in a special protected ceremony (marriage), or not at all.[16] Cecil, having failed to maintain her virginal status, is implicated, tainted by desire. She is a prostitute, circulates repeatedly as an object in the cash economy.

The gender logic always has class implications. Thick's hatred for the upper-class male medical students has a sexual valence: Thick resents their arrogance, their valuation of him as "matter," which puts him into the subject position of a passive thing, a woman. Against this he asserts a manly contempt of the medical students and attempts to castrate Eugene symbolically through the rape of Cecil.

---

[15]Caroline Walker Bynum, *Fragmentation and Redemption* (New York: Zone, 1992), p. 200: "medieval thinkers associated body with woman."

[16]See Gayle Rubin, "The Traffic in Women: Notes on the 'Political Economy' of Sex," in Rayna R. Reiter, ed., *Toward an Anthropology of Women* (New York: Monthly Review Press, 1975).

In *Marietta*, then, the sensationalist novel appropriates the cultural poetics of anatomy: the cult of dissectors; the anatomist's power over the living and dead body, over the lower classes, over women; dissection as rape (or seduction) of the cadaver; body snatching as a rape of the grave; body snatching and dissection as posthumous punishment; the body reduced to the status of commodity; the body reduced to the status of inert matter (and thus the field for scientific investigation).

2. Gothic anatomy: *The Quaker City*

> "It's my opinion that you'd make a bad subject for the dissectin' table!"
>
> —Devil-Bug, choking Luke Harvey
> [*The Quaker City* (1845), p. 266]

Marietta was a marginal work, an obscure specimen of the "yellow-covered novel."[17] But in the case of *The Quaker City* and its author, George Lippard (1822–1854), we have a literary phenomenon. Lippard was the premier antebellum narrativist of sexual danger and a leading exponent of morbid romanticism (along with his friend Edgar Allan Poe). An 1849 article in *Godey's Ladies Book* appraised him as "the most popular writer of the day," the best selling American novelist of his time.[18] In his short life (he died at the

---

[17]Thanks to Thomas Augst for sharing his research with me on the antebellum mercantile library and reading room; he conducted a quick search of some book lending and purchase records in antebellum Philadelphia and Boston libraries, and failed to find *Marietta* or other novels by Robinson.

[18]See David S. Reynolds, *George Lippard* (Boston: Twayne Publishers, 1982); idem, ed., *George Lippard, Prophet of Protest: Writings of an American Radical* (New York: Peter Lang Publishers, 1983); George Lippard, *The Quaker City* . . ., ed. and intro. D.S. Reynolds (Amherst: University of Massachusetts Press, 1995), pp. vii–xli; Michael Denning, *Mechanic Accents: Dime Novels and Working-Class Culture in America* (New York: Verso, 1987), pp. 85–117 (qtd. in Denning, p. 87). Reynolds, *Beneath the American Renaissance: The Subversive Imagination in the Age of Emerson and Melville* (New York: Knopf, 1988), pp. 204–09, says that *The Quaker City* sold 60,000 copies its first year (as a book, 1845), and averaged 30,000 per year for the next five years, making it the bestselling novel in America until Harriet Beecher Stowe's *Uncle Tom's Cabin* (1852). See also "Pen, Press, and Pencil," *Potter's American Monthly* 12 (1878): pp. 350–51; Julia Curtis, "Philadelphia in an Uproar: *The Monks of Monk Hall*, 1844," *Theatre History Studies* 5 (1985): pp. 41–47. Lippard, *Quaker City* (1845), p. 2, boasted that his book "was more attacked, and more read, than any work of American fiction ever published."

age of 32), he combined the roles of aesthete, and social critic and activist (he labeled himself a "red republican").[19] Though not quite an avant-gardist (except politically), Lippard mounted a kind of revolt against bourgeois formalism.[20] His serial novels, in the mysteries-of-the-city genre invented by Eugene Sue, are shapeless, hastily written; they travel haphazardly forward and backward in time; protagonists drop out, supplanted by new ones, without rhyme or reason.[21] There are occasional poetic flights ("on the opposite side of the way, a mass of miserable frame houses seemed about to commit suicide and fling themselves madly into the gutter") and surprising narrative developments, but more often, stock image piled upon stock image.[22] The overall effect, however—the grotesque characters, bitter sarcasm, bizarre plot turns, hyper-emotionalism, and idiosyncratic politics (a stew of egalitarianism, fraternalism, Americanism, and Christian sentimentalism)—is one of great originality.

The action in Lippard's convoluted 1844 serial novel, *The Quaker City,* seems to take place in a fever delirium; characters sweat, spasm, ache, tremble and hallucinate. Here is a typical passage, a description of a middle-aged merchant who is seized by a rippling succession of emotions when confronted with evidence of his young wife's infidelity:

> his countenance . . . was like a mirror, in which different faces are seen, one after another, by sudden transition. At first his face grew crimson, then it was pale as death in an instant. Then his lips dropped apart, and his eyes were covered with a glassy film. Then a deep wrinkle shot upward between his

---

[19]*The Quaker City* [newspaper], 3-31-1849: p. 3; all other citations of *The Quaker City* refer to the 1845 edition of the book, except where otherwise noted.

[20]Formalism in fiction in this period was not all that formal—the form and practice of the serial novel and newspaper ephemera militated against it—but Lippard was at the wild end of the spectrum. Better examples of the revolt against literary convention would be Whitman's *Leaves of Grass* and Melville's *The Confidence Man.*

[21]See Lippard, *The Quaker City* (Philadelphia, 1845); *The Nazarene; or, the Last of the Washingtons, a Revelation of Philadelphia, New York, and Washington, in the Year 1844* (Philadelphia, 1846); *The Monk of Wissahikon* (Wissahikon, PA, 1848); *The Empire City; or, New York By Night and Day, Its Aristocracy and Its Dollars* [1850] (Philadelphia, 1864); *New York: Its Upper Ten and Lower Million* (Cincinnati, 1853). For the mysteries-of-the-city genre, see Denning, *Mechanic Accents*, pp. 85–117, who argues, p. 90, that *The Quaker City*'s "sinusoidal structure" (in my reading shapelessness) is not "premature modernism," but "replicates the narrative structure" of the antebellum newspaper.

[22]*Quaker City*, p. 42.

> brows, and then, black and ghastly, the circles of discolored flesh were visible beneath each eye. The quivering nostrils—the trembling hands—the heaving chest . . . .[23]

Narrative developments produce effects on the bodies of his characters, providing a model of the effects of sensationalist prose on the reader (and, via the mechanism of reader identification, contributing to them). Genteel critics typically reacted to such stylistic devices by denouncing Lippard as a member of "the raw head and bloody bones school" of literature.[24]

The Quaker City is completely excessive, even by the elastic standards of gothic sensationalism. Much of the novel is set in "Monk Hall," a dark gothic mansion with hellish basements and sub-basements, and sub-sub-basements, labyrinthine unlit corridors, trap-doors, fake walls, vaults, and concealed tunnels that reach outward to distant parts of the city. Monk Hall is a private club where the male elite of Philadelphia go to revel in their hypocrisy. Safe from the scrutiny of the outside world, they gamble and drink; debauch virgins and seduce married women; engage in cruel banter and sadistic pranks; torture, humiliate, drug, and murder enemies and inconvenient partners; and laugh off their public professions of religious, political, and social piety:

> From the eloquent, the learned, and . . . the pious of the Quaker City, the old Skeleton-Monk had selected the members of his band. Here were the lawyers from the court, doctors from the school, and judges . . . from the bench. Here too, ruddy and round faced, sat a demure parson, whose white hands and soft words, had made him the idol of his wealthy congregation. Here was a puffy-faced Editor side by side with a Magazine proprietor; here were sleek-visaged tradesmen, with round faces and gouty hands, whose voices had re-echoed the prayer and the psalm in the aristocratic church, not longer than a Sunday ago; here were solemn-faced merchants, whose names were wont to figure largely in the records of 'Bible Societies', 'Tract Societies' and 'Send Flannel-to-the-South-Sea-Islanders Societies . . . Moderately drunk, or deeply drunk, or vilely drunk, all . . . kept up a running fire of oaths, disjointed remarks, . . . and snatches of bacchanalian

---

[23]*Quaker City*, p. 38.
[24]Reynolds, introduction, in Lippard, *The Quaker City* (1995), p. xiv.

> songs, slightly improved by a peculiar chorus of hiccups. [*The Quaker City*, p. 48]

The political message is that "The monks of Monk Hall," the professional and commercial elite, comprise an exclusive conspiratorial body that presents a danger to true Christianity and the democratic republic. In other novels, Lippard suggests that such men are part of a malign cabal that stretches back to the days of Christ (they crucified Jesus), through the Spanish Inquisition (which they helped instigate and administer), to the American Revolution (which they opposed).

This conspiratorial bourgeois elite aspires to become a new aristocracy (in some ways worse than the European aristocracy because of its parvenu ignorance and insecurity) so as to better victimize the honest small tradesman, the journeyman, the seamstress. At every opportunity, they mount multiple attacks on political, religious, and mercantile virtue—but, most insidiously, they privately claim a seigneurial privilege, the license to seduce and deflower virtuous young women. *The Quaker City* is a narrative thicket of assaults on, and defenses of, the sexual honor of beautiful virgins. Lippard's avowed plan, to "describe all the phases of a corrupt social system, as manifested in the city of Philadelphia," the "colossal vices and the terrible deformities, presented in the social system of this Large City in the Nineteenth Century," turns out to be "founded upon the following idea":

> *That the seduction of a poor and innocent girl, is . . . worse than the murder of the body, for it is the assassination of the soul. If the murderer deserves death by the gallows, then the assassin of chastity and maidenhood is worthy of death by the hands of any man, and in any place.* [*The Quaker City*, p. 1; Lippard's emphasis]

Grave-robbing and unscrupulous dissection are central to this web of vice. The concierge of Monk Hall, Devil-Bug, one of the most memorable characters in American fiction, is a murderer, blackmailer, thief, hangman—simultaneously the figure of death and a perversely transgressive "animal" vitality. Sporting a working-class Irish/German/Scottish accent, he takes ghoulish delight in robbing graves:

> "The *doctor* sent for me last night; the one what wants me to steal dead bodies for him. I must go airly in the mornin'; he pays me well; and I likes the business. . . . To creep over the

> well o' some grave yard in the dead o' the night, and with a spade in yer hand, to turn up the airth of a new made grave! To mash the coffin lid into small pieces with a blow o' the spade, and to drag the stiff corpse out from its restin' place, with the shroud so white and clean, spotted by the damp clay! To kiver the corpse with an old over-coat or a coffee bag, and bear it off to the doctor, with his penknifes and his daggers and his gim'lets! Hoo, hoo!" he emitted a wild imitation of the screech-owl, from his compressed teeth, "sich a jolly business!" [*The Quaker City*, p. 311]

Devil-Bug's brutish callousness bears a family resemblance to the scientific disinterestedness adopted by the anatomist (who customarily disavows any social or moral connection to his body snatchers):

> There was a great deal of the philosopher in Devil-Bug. Never a doctor of all the schools, with his dissecting knife in hand and the corpse of a subject before him, could have manifested more nerve and coolness than the savage of Monk-Hall. [*The Quaker City*, p. 311]

The Quaker City features a succession of attempted and consummated murders, mutilations, seductions, premature burials, despoiled graves, grave robberies, and dissections. Skeletons, skulls, dead bodies, and coffins prop up scenes and soliloquies—morbid romanticism runs full throttle. There are several death visions, including a premonition of the apocalypse to come in the America of 1950!:

> The phantoms of his murdered victims rose before him; the man with the broken jaw and the lolling tongue, the woman with the blood falling drop by drop from the hollow skull. . . . Then the dream became confused and wandering. Devil-Bug was surrounded by a hazy atmosphere, with coffins floating slowly past, and the stars shining through the eyes of skulls, and the sun pouring his livid light straight downward into a wilderness of new-made graves, which extended yawning and dismal over the surface of a boundless plain. [*The Quaker City*, pp. 312–13]

The Gothic had always taken its requisite imagery from *memento mori*, the *danse macabre*, and so on, but never so excessively. In *The Quaker City*, these generic images are supplemented with anatomical imagery, which is meant to shock the reader, but also to

serve as a social critique. An encounter between Byrnewood Arlington, the hero of most of the book, and Lorrimer, who methodically designs to debauch Arlington's sister, produces this exchange:

> [Arlington:] "Do you see this flame? Sooner than agree to leave these walls, without—my—my—without Mary, pure and stainless, mark ye, I would hold this good right hand in the blaze of this lamp, until flesh fell blackened and festering from the very bone. Are you answered?"
>
> [Lorrimer:] "Excuse me, sir—I was not speaking of any *anatomical experiments*; however interesting such little efforts in the surgical line, may be to you. . . ." [*The Quaker City*, p. 86; Lippard's emphasis]

This is a dialogue between moral sentiment (which is distributed throughout the body, even burns the flesh off the bone) and immoral anatomico-clinical detachment. Anatomical detachment suppresses all affect, mobilizes the body for the narrow, singular purpose of a genital satisfaction that destroys its object: the goal of the sport of male conquest. Moral sentiment is tied to fulsome emotion. The two stances cannot coexist in the same body. Byrnewood is inundated by a tidal wave of emotion. His detachment has been shattered by the news that Lorrimer has deceived and is about to debauch his sister Mary. Lorrimer replies with undentable cool, tells Byrnewood that his invocation of self-mutilation, his strongest figure of speech, amounts to a trifling "anatomical experiment."

In a later scene, Mary's distraught parents beg Lorrimer to marry her, to "Save her from public shame." But, for the high-born Lorrimer, such a request only provides an easy opportunity to inflict another humiliation. He replies "with withering politeness," that is, without bodily affect: "Why the fact is my friends, I'm not a marrying man. . . . This affair is quite unpleasant and—your family and mine, are quite different in their style. You are not of our 'set' " [*The Quaker City*, p. 468]. The command of intellect over emotion, and accomplished sexual predation, are emblematic attributes of masculine aristocratic social practice. Female peers and superiors receive protection from sexual predation; everyone else is fair game, even those only a notch lower on the social scale.

Lippard links this predatory sexuality to science. Without the constraint of emotional ties and moral sentiment, the operation of mind is economical and precise, but monstrous, annihilating. Clinical reason is a genital force of will, directed toward the penetration of the bodies of its objects. Knowledge reduces its objects to the sta-

tus of disposable playthings, and invariably destroys them in play. Dissection (via the scalpel), mesmerism (via the gaze), close reading (via the gaze), and rape (via the phallus) are its representative (and morally equivalent) operations. Recurrent allusions to dissection reinforce the point:

> Lorrimer looked at him . . . and then, taking a small pen-knife from his pocket, began to pare his nails . . . as though he didn't exactly know what to do with himself. He wore the careless and easy look of a gentleman, who having just dined, is wondering where in the deuce he shall spend the afternoon.
>
> "I say, Byrnie my boy—" he cried suddenly, with his eyes fixed on the operations of the knife—"Devilish odd, ain't it? That little affair of yours, with *Annie?* Wonder if she has any *brother?* Keen cut that—"
>
> Had Mr. Lorrimer intended the allusion, about the keenness of the 'cut,' for Byrnewood instead of his nail-paring knife, the remark would, perhaps have been equally applicable. Byrnewood shivered at the name of Annie, as though an ague-fit had passed suddenly over him. The 'cut' was rather keen, and somewhat deep. This careless kind of intellectual surgery, sometimes makes ghastly wounds in the soul, which it so pleasantly dissects. [*The Quaker City*, pp. 86–87]

Byrnewood's emotional outpourings undo the homosocial bond that previously existed between him and Lorrimer, a bond constructed around their shared sexual interests. Byrnewood had been a debaucher himself, and fraternally cheered Lorrimer on in his debauchery, until learning that the woman to be seduced was his sister. Then emotion, a feminine trait that disorders the commanding masculine ego, overtakes it. As in *Marietta*, emotion demasculinizes, but here it is infantilizing rather than feminizing: Lorrimer addresses Byrnewood as "Byrnie my boy," a speech act that castrates him.

Lorrimer, for his part, celebrates deception, seduction, rape, defloration, as a disciplinary practice: "Woman—the means of securing her affection, of compassing her ruin, of enjoying her beauty, has been my book, my study, my science, nay my *profession*" [*The Quaker City*, p. 88]. Science and professionalism, unencumbered by moral sentiment, are linked to male desire. Lorrimer has made a science of debauchery, takes his virgins in the same way that the anatomist cuts up his subject. A page later, the anatomical metaphor recurs: "the consciousness that he [Byrnewood] was in the power of this libertine . . . came stealing round his heart, like the probings of

a surgeon's knife" [*The Quaker City*, p. 89]. Byrnewood, too, has become Lorrimer's anatomical subject; the loss of sexual honor destroys not only the virgin but also her family members.

Lorrimer's science has its most profound effect, of course, on its chosen object, Mary Arlington. It operates via an appropriating, penetrating "read" or "gaze": "[Lorrimer] knew every leaf of woman's many-leaved heart, and knew how to apply the revealings, which the fair book opened to his gaze. His gaze, in some cases, in itself was fascination. . . ." [*The Quaker City*, p. 77]. According to Foucault, anatomical dissection is the key performance of an epistemological revolution, the new relationship between medicine and its object (the body). The characteristic methodology of the new medicine is a disciplined, systematic form of looking, a surveying, penetrating "clinical gaze" that is trained to regard the living and dead body as the same class of objects. This purposeful but disinterested view taxonomizes the field, constitutes objects of discourse, and, like dissection, penetrates the opaque material object, makes it transparent, legible.[25] In the nineteenth century, this gaze becomes a defining feature of masculinist bourgeois subjectivity and, as it diffuses to a wider public, comes to be identified with modernity—and dissection.

Sensationalist fiction characteristically plays on the disjunction between the discourse of the new medical epistemology and its performance. In *The Quaker City*, the clinical gaze is not disinterested, but murderously possessive, erotically charged, a contradiction that discredits medical authority on the very grounds on which it is constituted. At the same time, Lippard uses the image of the anatomico-clinical gaze—and its subject—to arouse the reader. The gaze, the emblematic procedure of rationalist science, is incorporated into the idiom of gothic romanticism.

---

[25]Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, tr. A.M. Sheridan Smith (New York: Pantheon, 1973), p. 90: "New objects . . . present themselves to the medical gaze . . . at the same time as the knowing subject reorganizes himself, changes himself, and begins to function in a new way." The gazing subject, constituted by the objects of his gaze, is reconstituted as he becomes the object of his own gaze. "It was not . . . the conception of disease that changed first and later the way in which it was recognized; nor was it the signaletic system that was changed first and then the theory; but together, and at a deeper level, the relation between the disease and this gaze to which it offers itself and which at the same time it constitutes."

Prior to her subjection to the gaze, Mary has a "stainless soul"; her love for Lorrimer is disembodied, pure:

> And was there aught of *earth* in this love? Did the fever of sensual passion throb in the pulse of her virgin blood? Did she love Lorimer [sic] because his eye was bright, his form magnificent, his countenance full of healthy manliness? No, no, no! . . . She loved Lorrimer for a something which he did not possess, which vile worldlings of his class never will possess. For the magic with which her fancy had enshrouded his face and form, she loved him, for the wierd [sic] fascination which *her own soul* had flung around his very existence, for a dream in which he was the idol, for a waking trance . . ., for imagination, for fancy, for any thing but *sense*, she loved him. . . . [*The Quaker City*, pp. 72–73]

Mary is innocent of "sense," meaning embodied sensation and sexual desire, but the coolly deceptive Lorrimer plays like a surgeon on the flesh of his female victims. "[L]ooking her steadily in the eye, with a deep gaze, which every instant grew more vivid and burning" [*The Quaker City*, p. 109], Lorrimer captures her, scopically enters her. His technical command of the gaze enables him to embody the disembodied virgin, to raise her "animal nature," the carnal body of "pulsing" and "feverish throbbings," to warm her heart with "convulsive beatings"—the code words which stand for the rhythm of genital excitation.

These are unrepresentable in her consciousness (and only barely representable in the text). In *The Quaker City*, the capacity for sexual sensation, for sexual pleasure, is a dangerous potential that women cannot realize on their own:

> She knew not that in her own organization, were hidden the sympathies of an animal as well as of an intellectual nature, that the blood in her veins only waited an opportunity to betray her, that in the very atmosphere of the holiest love of woman, crouched a sleeping fiend, who at the first whisperings of her Wronger, would arise with hot breath and blood shot eyes to wreak eternal ruin on her, woman's-honor.
>
> For this is the doctrine we deem it right to hold in regard to woman. Like man she is a combination of an animal, with an intellectual nature. Unlike man her animal nature is a *passive* thing, that must be roused ere it will develop itself in action. Let the intellectual nature of woman, be the only object of

> man's influence, and woman will love him most wholly. But let him play with her animal nature as you would toy with the machinery of a watch, let him rouse the treacherous blood, let him fan the pulse into quick, feverish throbbings, let him warm the heart with convulsive beatings, and the woman becomes, like himself, but a mere animal. *Sense* rises like a vapor, and utter darkens *Soul*. [*The Quaker City*, p. 73]

Lippard's "doctrine" of the body is gendered. Masculine reason, linked to desire, operates through the gaze. The will to be embodied and to act on bodily desires is held in check only by "the heart" or "spirit." Female "intellectual nature" coexists with an underflowing "animal nature"; it is a "passive thing," at least until seduction and defloration. At that point, the polluted woman either dies or becomes a prostitute or virago, socially dead beings who take vampiric pleasure in passing the taint on to undefiled virgins:

> How many of the graves in an hundred churchyards, graves of the fair and beautiful, had been dug by the gouty hands of the vile old hag, who sate chuckling in her quiet arm-chair? How many of the betrayed maidens, found rotting on the rivers waves, dangling from the garret rafter, starving in the streets, or resting, vile and loathsome, in the Green-house ["the house for the unknown dead"]; how many of these will, at the last day when the accounts of this lovely earth will be closed forever, rise up and curse the old hag with their ruin, with their shame, with their unwept death? [*The Quaker City*, p. 66]

3. The cabinet of Dr. McTourniquet

Lippard narrates social and gender relations within a gothic literary idiom that includes the characteristic moves of anatomical performance and discourse—the unearthing and exhibition of dead bodies, dissection, clinical detachment and the gaze, science, professionalism. *The Quaker City* also includes a direct critique of anatomy. In the 1840s, Philadelphia was regarded as the capital of American medicine, the nation's premier center for the study of anatomy. Lippard detested its large medical establishment and *The Quaker City* contains many mocking attacks on the anatomical basis of medical authority. The Philadelphia medical establishment is represented by Dr. McTourniquet, a buffoonish supporter of Henry Clay and the

Tariff.[26] In one scene, McTourniquet takes Livingstone, the cuckolded merchant, around his anatomical museum, showing off his prize specimens:

> A little of every thing from all parts of the world. In that jar a negro child with two heads. Preserved in spirits. Capital specimen of a double-headed negro. Ought to have been at [Surgeon's] Hall this morning; cut off a poor fellow's arm. Took it quite lively. . . . Singular specimen of an arm that. In that long jar. Took it off the body of a man who was hung for robbing the mail. Hand had seven fingers . . ." [*The Quaker City*, p. 177]

Livingstone, who intends to murder his unfaithful wife, leads McTourniquet into a discussion of deadly and untraceable poisons. The thickheaded doctor informs him of a poison that makes the "victim lay as though he (or she) had but fallen asleep" [*The Quaker City*, p. 179]; he has a treatise in his collection on the subject and shows it off:

> . . . Livingstone took the small volume of manuscript in his hand. . . . He stood in McTourniquet's Museum, surrounded by shelves piled with surgical curiosities, preserved in jars, or hanging by parti-colored strings, or, yet again, huddled carelessly together. . . . Dead men in fragments, in great pieces and little, in all shapes and every form, were scattered around. In the full light of the window, fashioned in the ceiling of the room, stood a grisly skeleton, one hand placed on his thighbone, while the other, with the fingers stuck in the cavity of the nose, seemed performing the stale jest, common with the boys along the street. "You can't come it Mister, by no manner of means!" that gesture said, as plainly as a skeleton's gesture can say. [*The Quaker City*, pp. 179–80]

Just as stock stage figures such as Bowery B'hoy delight in offending bourgeois propriety, the dead anatomical exhibits taunt the living, mock Livingstone's cuckoldry and McTourniquet's banalities. Yet compared to Lorrimer and Devil-Bug, McTourniquet is a lightweight, obtuse but not terribly evil.

---

[26]Edinburgh was still a prestigious center of medical study in the 1840s and Scottish anatomists were disproportionately represented in the Philadelphia medical establishment. McTourniquet may have been modeled on a specific figure such as George McClellan or James M'Clintock.

In a later chapter, "The Dissecting Room," McTourniquet blithely invites Byrnewood to "witness a dissection of the human subject": "It's quite a treat to the uninitiated" [*The Quaker City*, p. 370]. Byrnewood accepts—he is obsessed with the image of his sister's dead body "laid on the foul altar of a dissecting table" [*The Quaker City*, p. 368]—and they enter "Dissecting Hall." The "treat" turns out to be a spectacle of decomposing bodies and body parts, attended by a jeering chorus of students. The passage, one of the most extraordinary in nineteenth-century fiction, is worth quoting at length:

> Around the room . . . were placed some twenty oblong tables. . . . Bending over each table was a young man, whose long hair and characteristic look of frankness and recklessness combined, betrayed the Medical Student of the Quaker City. At some of the tables were groups of two and three, talking earnestly together, knife in hand all the while, and the whole body of students wore the same dark apron reaching to the shoulders, and each arm was defended by a false sleeve of coarse muslin. And on each table, sweltering and festering in the sunlight, lay the remains of a woman and child and a man. . . .
>
> Here a ghastly head, placed upright, with the livid lips parted in a hideous grin, received the gay light of the sun, full on its glassy eyeballs, there a mass of flesh and sinews and bones, shone in the beams of the morning, as corruption only can shine. A Soul once shone from those eyes, a voice once spoke from those lips!
>
> Here lay an arm, whose soft and beautiful outlines, were terminated by a small and graceful hand, and over the alabaster arm and the snowy hand, the blue taint of decay spread like a foul curse, turning loveliness into loathing. There in the full glare of the sunlight was spread a reeking trunk, lopped short below the waist, with loathsomeness and beauty combined in one horrible embrace. The head had been severed and below the purple neck two white globes, the bosom of what had once been woman, were perceptible in the light. And the Rainbow of corruption crept like a foul serpent around that bosom. For Corruption has its Rainbow; and blue and red and purple and grey and pink and orange were mingled together on that trunk in one repulsive mass of decay. And on this fair bosom hands of affection had been pressed, or sweet

young children had nestled; or maybe the white skin had crimsoned to a lover's kiss!

"I say Bob, this must have been a jolly old chap!" cried a young gentleman whose snub nose harmonized with his wide mouth and cross eyes. "No doubt these lips have opened with several thousand jolly grins in their time—now look at them! Pah! How blue and livid."

And he tossed the head of the old man down upon the table, twining his fingers in the white hairs, while his knife severed the flesh from the brow.

"Sweet girl, this was once upon a time! Many a poor devil has been dying for love of her eyes and lips. Just now she dont look altogether loveable. The eyes staring from their sockets and the lips falling to pieces! And then the bosom, ha, ha! The Scalpel makes love to it now!" And the sunbeams glistened upon the blade of the knife as it played briskly over the livid flesh.

"Wonder how many people have shaken hands with this old fellow?" muttered another student, with dark eyes and stiff lank black hair. "Just look at this hand—old and withered and hardened by toil. How these cramped fingers have clutched at the dollars and the pennies—ha, ha!". . .

"He, he, he!" laughed a young Student in tow-colored hair and a pear nose. "Jist look at that—good, capital!"

He had placed the mangled body of a dead man, against the wall in a sitting posture, with the knees drawn up to the chin, and the right hand fixed between one knee and the face, with the fingers outspread and the thumb pressed upon the nose, in a gesture very much the vogue among dirty little boys, rowdies, and cabmen.

"Is'nt that the touch?" laughed the tow-haired Student. "Does'nt he say '*Cant come it!*' plain as chalk? And then that eye half shut—is'nt the wink perfect!"

"Ha, ha! Ho! Ho! Good—capital!" chorused some dozen students, grotesque mockery streamed the yellow sunshine coloring the leaden eyeballs and the hanging lip with hues of vivid gold. [*The Quaker City*, pp. 370–72][27]

---

[27]The repeated references to a corrupting or ghastly light should be read against the conventional tropes of "enlightenment" illuminism.

The students are the pupils of Signor Ravoni, a mysterious anatomist-sorcerer-alienist-theologian-messiah, who becomes the central figure of the last section of the book. McTourniquet detests him:

> ". . . this Italian or Frenchman or Turk or Jew, no sooner puts his foot on the soil of the Quaker City, than he astonishes the Faculty; strikes Science dumb; plucks Theology by the beard, and in fact walks over everybody's notions on everything—"
>
> "How does he do all this?"
>
> "That's the mystery. He walked into our Medical Halls unbidden, and proved himself a great Anatomist, a splendid Surgeon. No one has had the bravery or impudence to question him concerning his former life, because there's a cold impenetrable gleam in his eye, that few men would like to brave . . . .
>
> "An unknown Pretender appears in the Quaker city, and lo! Everybody hastens to entrust him with their own lives, and the lives of those they love. You ask how? He gives out that he will cure the Insane, and before a day is past he has an hundred patients under his care."
>
> "Does he cure them?"
>
> "Ha, ha! The ugly ones he cures, and returns to their relatives with all possible despatch. But the women, and the *handsome* women, ho, ho! 'It will require *time*,' is his invariable answer. And then he has established a Lecture Room, where he gives lectures on Anatomy. Egad! Our students are crazy with the fellow—" [*The Quaker City*, p. 369]

Ravoni stands as a reproach to the orthodox medical establishment, to scientific reason itself. Other anatomists just map the body, flatten it out. He extracts its essence, plumbs its depths. Against the superficial neo-classical illuminism of *au courant* anatomical medicine, he practices a superior, dark, ancient science, alchemy. His gaze is of the highest intensity, "alive with the rays of magnetic power" [*The Quaker City*, p. 375]. Women are irresistibly drawn and held in its field. It even reduces Devil-Bug, up to this point the novel's incarnation of evil, to a whimpering cur; the hitherto indomitable monster becomes the wizard's cringing lackey. Ravoni's powers are so great that he can even arrest death: he himself is hundreds of years old.

In another extraordinary scene, the medical establishment of Philadelphia, five hundred students and professors, assemble at an anatomical theater, to see Ravoni demonstrate "some important

discoveries in Anatomy . . . some new Theory of the origin of life," illustrated "by the dissection of a subject" [*The Quaker City*, p. 369]. The body snatchers (one of whom is Devil-Bug) produce a body, stolen from the Almshouse graveyard[28] and wrapped in a coat:

> Ravoni . . . slowly flung aside the tattered overcoat which enveloped the dead man.
>
> There was an awful silence. Every eye beheld the corpse, and every heart grew cold with dread. Ravoni himself at the sight of that hideous spectacle started backward with a pale cheek and a trembling lip. Then . . . a murmured cry of horror shook the room. . . . From head to foot, along the trunk and over each limb, that corpse was all one cankering sore, one loathsome blotch. Features on the face there were none; brow and lip and cheek were all one hideous ulcer. The eye-balls were spotted with clotted blood; the mouth a cavern of corruption; the very hair was thick with festering pollution. I[t] was the corpse of a man who had died from . . . the most infectious of all epidemics, a curse at whose name beauty shudders and grave science grows pale—the small-pox. Better to look into the plague-pit where man and woman and babe lay mingled together, one reeking mass of quick lime and gory flesh, than to have gazed upon that corpse extended on the Dissecting table before the eyes of five hundred living men! . . .
>
> Ravoni stood silent and pale. . . . There he stood with eternal youth in his veins but in his twelve brief hours, he might lay a foul thing of ulcers and blotches, like the corse before his eyes. For the common phases of this disease, there were remedies; but let a single infectious atom breathed from the lips of a corse like this, enter the lips of living man, and no arm under God's sky could bring relief.
>
> . . . To lay a mass of gory flesh and stagnant blood, to decay before your last hour, to anticipate the rottenness of the grave while life yet lingers in your veins! That thought, paled even the cheek of Ravoni, and the spectators, Doctors, Student and Professor, were spell-bound with a fear worse than death.

---

[28]Here, as in many other particulars, Lippard's details are accurate. According to Charles Lawrence, *History of the Philadelphia Almshouses and Hospitals* (Philadelphia, 1905), pp. 161–64, in the 1840s bodies were systematically culled from the almshouse in order to supply the dissecting tables of Philadelphia's medical colleges.

> A wild cry of horror shook the room, and then in one mass the audience rushed toward the door. It was a living picture of a panic. . . . [T]he dense throng rushed against the door, crushing all who stood near its panels until they howled in very agony, and then came another rush and another yell! There was a wild crashing sound; the door gave way; splintered into fragments it fell before the living mass, and through the opened passage, the panic-stricken crowd rushed from the place of death. [*The Quaker City*, pp. 373–75]

The cowardice and hypocrisy of anatomical medicine stand revealed. The anatomical enclosure of the body, the disenchantment of the flesh, is a puny thing beside the profundity of bodily corruption, the bodily sublime. Devil-Bug laughs: "Ho, ho, ho! . . . The doctor and the students all skeered to death by a bundle o' small pox!" [*The Quaker City*, p. 375]. Against the bantering mockery of the dissecting room, against the anatomical pose of detachment, death and the decomposing body prevail. Science is exposed as ineffectual, superficial.

This romantic critique of reason is conducted in visceralist terms, in the language of flesh, a vocabulary of the body and bodily affects that is excluded from genteel discourse. The diseased body, the desirous body, far exceed the anatomical body, the body of anatomical texts and dissecting tables. It bursts with moral and immoral significance; it articulates desire, fear, hatred; it works on the spirit.

The doctors who comprise the medical profession try to stand above and outside corporeality. But, for all their contempt of the dissected body and the working people who stand in a "mass" against the "intelligent" individual, "a mass of gory flesh" reduces the physicians themselves to a "living mass," a body of humanity. The audience (including McTourniquet) stampedes out of the anatomical theater. Ravoni remains standing beside the corpse; Byrnewood Arlington, "with long black hair and a flashing eye," stands by his side:

> "Thou hast a firm soul," spoke the Sorcerer, . . . his eyes shone and his brow warmed with a sudden enthusiasm, "By the Soul of Ravoni thou shall be one of the Chosen; thou shalt be a Priest of the Faith!" [*The Quaker City*, p. 375]

Ravoni is bent on supplanting Christianity with a cult of the "Will" that is both a religion and a science, with himself as messiah.

New, but also ancient, this Faustian cult of knowledge will recuperate the forgotten power of ancient magic, even the power to resurrect the dead:

> "The new Faith which shall arise over the ashes of the creeds and superstitions of this day. The Faith which dwelt in the hearts of men, ere the Sword of the Jew or the Cross of the Christian or the Crescent of the Sorcerer arose on the horizon of man's soul, scattering pestilence and death, wherever they flashed or shone! That Faith, buried for long, long centuries which man in the olden time, in the world's youth of promise, loved and cherished, which raised him to godhead, and made the Universe itself his own, that Faith will we raise from the grim ruins of fable and superstition! And the old Faith, revised and re-created shall be our New Religion of hope to Man!"
>
> The words of the Sorcerer were wild and strange, but his look and tone, were lightning and music to Byrnewood's soul. . . . Slowly he reached forth his arm, and with his eyes fixed on the eyes of Ravoni, he seized the Sorcerer by the hand.
>
> "*This hour shalt thou behold the dead arise!*" exclaimed Ravoni. . . . "Come!" [The Quaker City, p. 375]

Ravoni's proto-Nietzchean religion does what the anatomical narrative of reason versus superstition only trifles with: resurrects the dead, destroys "superstition" (here redefined to include Christianity), brings on a new millennium. Unchecked by moral encumbrance, the new order promises a boundless expansion of human agency, fusing reason, desire, and revelation—a triumph of anatomical will far beyond the reach of contemporary anatomy. In the end, however, this too is thwarted. Ravoni is undone through Devil-Bug's unlikely fatherly love for the innocent Mabel. Christian spirit, moral sentiment, wins out over embodied, desirous reason, over the way of the flesh.

4. "The most poetical topic in the world"

> "And sich a purty corse!" cried Mrs. Wilson, "Jist look there! Did ever ye see sich hair? So curly and long, and so like gold. Did you ever see sich a mouth?"
>
> —Mrs. Wilson, to Ravoni, *The Quaker City* (p. 348)

And yet the performance of the text says something different. *The Quaker City* ostensibly narrates the conflict between flesh, mind, and spirit, a struggle in which moral sentiment enjoys a victory over voracious reason and the embodied self. Lippard avowed that his "motive in its composition" was "pure," "destitute of any idea of sensualism" [*The Quaker City*, p. 2], but his critics were surely correct on this point. The sensationalist novel has many affinities to pornography, and *The Quaker City* has many pornographic passages, usually involving a beautiful young woman who is dead or seems so. Take, for example, this description of Mabel, a young virgin who lies in a trance that mimics death:

> . . . on the altar, lay a stiffened corpse, whose outlines were dimly seen through the folds of a white cloth, flung lightly over each icy limb. There was a beauty in that corpse, and grace, for the cloth was moulded into soft folds, as though it veiled a woman's form. The feet were thrust upward, the arms folded over the chest, and the globes of the bosom rose gently in the light, even beneath their thick disguise. The . . . outlines of a countenance, which death had only made more sternly beautiful, were clear and apparent. . . . [*The Quaker City*, pp. 377–78]

Antebellum readers well understood the erotic coding of the "soft folds," "globes of the bosom," and emergent "worms":

> Yet she was dead, ah, cold and dead! And the light streamed warmly over the marble whiteness of that uncovered form, revealing beauties which the worms were soon to riot. Over the round limbs, over the white bosom, over the beaming face the worms would crawl, marking their progress with the blue taint of decay. And Ravoni could raise this corse to life again? Mockery of mockeries! [*The Quaker City*, pp. 382–83]

What explains this close identification between Eros and Thanatos, the female cadaver as the object of male desire?—"unquestionably the most poetical topic in the world."[29] The only bodies permitted erotic representation in *The Quaker City* are dead, asleep, or seemingly dead women. In the antebellum era, public display of unclothed female flesh was taboo. Only in anatomy and fine art could the naked body find legitimate representation, and in

---

[29]For an extended discussion of this topic, see Elisabeth Bronfen, *Over Her Dead Body: Death, Femininity and the Aesthetic* (New York: Routledge, 1992).

those domains, whose erotic potential was evident, this was circumscribed, the subject of tricky negotiation.

Death provided anatomy and fine art with their subject matter and legitimized, in varying degrees, the representation of flesh:

> It was the corse of a young beautiful woman. There was a smile on the lips, a calm glory beaming from the face, around whose swelling outlines, a warm mass of golden hair curled and twined and glistened. The round arms folded on the breast, the white fingers gently clasped, and the snowy bosom with the blue threaded veins, that bosom whose fulness bespoke the mother—ah! Death was there in holy beauty. Fairer form than that, did painter never shape, sweeter limbs than those did sculptor never carve. [*The Quaker City*, p. 383]

In death, the body becomes a naked or lightly veiled statue, identical to the classical representations that, by longstanding convention, carry both an erotic and moral valence. Death aestheticizes the body. The body is frozen (for a moment) into a representation that draws on a stock of classical imagery: the clothing of everyday life is replaced by a shroud, which is reminiscent of classical drapery. Death makes the skin pale—in the antebellum era, aesthetic convention dictated the paler the better. Death quiets the body, makes it fall into a beautiful repose. Antebellum gender ideology characteristically valued beautiful passivity as a feminine attribute.

At the same time, in death, the virginal female body, unclothed or dressed in a veil-like translucent shroud, undergoes a transformation that fixes its status, places it for eternity outside the "traffic of women" (just as married motherhood places a woman outside the cash-nexus, the market in sexual favors). The dead body becomes the object of moral contemplation. Its unavailability is easily converted into desirability: in death, the female body becomes a scarce commodity.

In much of nineteenth-century fiction, the beautiful cadaver is an icon. In narratives of the productive bourgeois self, it is deployed in opposition to the chaos and destructiveness of death. The eroticized corpse simultaneously articulates and represses the knowledge of the disordering, destroying pleasure of erotic desire. But as the dead body undergoes decomposition, it undergoes a moral metamorphosis, becomes a source of pollution. The decaying corpse is not a subject or an object, but an "abject," an ontological category that stands outside discourse as the opposite of value, the antithesis

of productivity and reproductivity. The decaying body disrupts labor discipline, reproductive discipline, sexual discipline.

Death, in both of these stages, is a boundary breached, just like sexual intercourse, where the boundary between bodies is breached (the special case which intensifies this erotic effect is the defloration of the virgin, a double boundary breached). Death (stereotypically represented as a masculine figure) invades the body and strips it of its will, its independent subjectivity. Like the mesmeric trance or even rape, death removes the obstacles that female agency places to male appropriation and penetration of the female body, via the gaze, phallus, or dissecting knife. The antebellum fascination with the dead body, as with mesmerism, stands as the expression of a desire to surrender the boundaries that define bourgeois personhood, a willful annihilation of the propertied self.

In fact, the regulation of female sexuality almost requires that Eros and Thanatos become equivalents. For women, the loss of virginity outside of marriage, or the violation of the marital bed by infidelity, is a social death. The debauched virgin and the adulterous wife, like the dead body, are sources of contamination and sites of desire. Defloration, like death, strips the female body of any defense against male sexual predation, but also sets in motion a pathological fecundity.

Death then, like sex, epitomizes self and other, even as it liquidates the self. Death purifies and reveals, but also corrupts and contaminates. In nineteenth-century fiction, the manner of death reveals the essence of the life. Death is the telos of the narrated life, a life navigated by a purposeful, moral self. A beautiful life requires a beautiful death; and its representative figure, in the sentimental and sensationalist narrative, is the beautiful woman (or, often, the beautiful child). But death is also an annihilation of self. In the erotics of death, the early stages are aestheticizing and iconically feminine; the latter stages masculine and ugly. As decomposition proceeds, worms consume the dead body—an operation that metaphorically encodes the destructive phallus and the consummation of desire. The body generates foul odors, loses symmetry and uniformity of coloring, etc. Death (like sexual desire) is what bourgeois morality and aesthetics cannot contain. Those without honor, those who lack moral sentiment, revel in ugly death (e.g., Devil-Bug). And this phenomenology of death recapitulates the Christian after-life: the decay of the body is hell, the place where negations are articulated through eternity.

5. The body turned inside out, and back again

> Both anatomy and belles-lettres are of equally noble descent; they have identical goals and an identical enemy—the devil—and there is absolutely no reason for them to fight. . . .
>
> —Anton Chekhov (1891)[30]

As we have seen, the procedures of gothic sensationalism stand as a reproach to the hegemonic valuation of mind, or even spirit, over body. In operating on the reader's body, the Gothic circumvents bourgeois discipline, the regulatory action of reason, and produces its own bodily effects. For Lippard, anatomy is a refusal of deeper knowledge, a vain and illegitimate attempt to coerce the body. Against the pretension of anatomical embodiment, Lippard uses the language of carnality, corruption, and desire. In hackwork like *Marietta*, visceralism is a technique, the procedure of sensationalism; in the works of Lippard it is elevated to the status of aesthetic principle, even a political program. Despite his own disavowals, Lippard turns the body inside out. Instead of reason penetrating and organizing the body, corruption, feeling, and desire pour out of the body. This is the revenge of matter over mind.

Even so, Lippard's gothic sensationalism and anatomy have some affinities. Anatomists deployed funerary iconology, skeletons, and anatomical objects to suggest their power over life and death (as evidenced by *Marietta*'s galvanic resurrection scene). In the nineteenth century, anatomy assimilated the romantic discourse of vital force, in "dynamic physiology" (which redistributed spirit to the working parts of the body), animal magnetism, and medical electricity. Within medical texts as well as sensationalist fiction, the mesmeric gaze, the seductive gaze, anticipated or was conflated with the clinical gaze: both appropriate their objects, constitute them, master them. Anatomy overlapped the Gothic—both operated in a liminal zone (real or imagined) between death and life, both deployed *memento mori*. Both worked the same tropes: the problem of power, will, and the boundaries of self. (Recall that mesmerism was a staple of the Gothic novel and a specialty of antebellum medical performance.) In early nineteenth-century anatomy museums, doctors' offices, hospitals, anatomical theaters, and dissecting rooms,

---

[30]Chekhov to Suvorin, 1891; qtd. in Aileen Kelly, "Chekhov the Subversive," *New York Review of Books*, 11-6-1997: p. 64; Kelly's translation.

physicians exhibited skeletons, crania, anatomical objects, death figures, themselves, to impart a libidinal charge. They too sought to engineer a physical impact on the bodies of their patients, colleagues, and society, to evoke fear, awe, and erotic arousal. In practice, the affectless clinical gaze was only partly developed in the medicine of the 1840s, a potential. The mockery of the medical students in "The Dissecting Room" was not yet that detachment which ruthlessly suppresses affect, ornament, metaphor, rhetorical flourish, and romantic narrative in favor of a methodical reductionist narrative, schematic illustration, and tabular columns. That version of the gaze, already taking shape in P.C.A. Louis's "numerical method," Claude Bernard's "experimental physiology," and Rudolf Virchow's "cellular pathology"—the great innovations of the experimental medicine of the 1840s and 1850s—was to be the ultimate trajectory of Western medicine.

Lippard sought to discredit medical (indeed all professional and class) authority, and to credit his own, via the romantic narrative of literary genius, the republican narrative of conspiracy against the people, the masculinist narrative of honor defended. But both Lippard and the anatomists operated on their subjects through a distinctive set of discursive practices: Lippard on the bodies of his readers, anatomists on their patients and cadavers. In order for the physician to authorize himself, he must dissect. His subject must be rendered speechless and helpless, inert (just as the characters in *The Quaker City* are rendered inert through hypnosis, drugging, burking). Lippard opposes anatomy as a rape of the body, a rape of the grave, but at the same time his critique was designed to titillate and shock the passive reader through erotic narratives of the dead female body. He may have seen through the anatomist, who cloaks desire in the rhetoric of disinterested science—but Lippard's own avowals of disinterestedness have as little credibility.

It would be easy to dismiss Lippard as a cranky anti-rationalist. His writings are idiosyncratic, but they exerted power insofar as they referred back to the lives of his readers. What Lippard wrote about—dark conspiracies of physicians, body snatchers, and secret orders that empowered a rapacious elite—had some plausibility. Antebellum Americans were subject to powerful, invisible forces—the (increasingly international) market economy, backroom party politics, the cloistered social and professional gatherings of new elites, and the speculative machinations of finance capital. These received representation in literary, theological, medical and political fantasies that focussed on powerful secret cults, most famously the

Masons and the Roman Catholic church.[31] At the same time, in the 1840s, body-snatching gangs and medical body-snatching conspiracies (unlike Masonic and Catholic conspiracies) did actually exist in many places. In a variety of ways, then, Lippard's fantastic creations gestured toward "the real." Even Devil-Bug, his most bizarre creation, corresponded to figures who could be found in the social experience of his readers: ghoulish characters like George T. Alberti, the body-snatching, fugitive-slave-catching, kidnapping, former hangman, who later became an extortionate petty politician in the Southwark district of Philadelphia, and William Cunningham ("Old Cunny"), the notorious head of a Cincinnati body-snatching gang.[32]

Sensationalist discourse provided a descriptive vocabulary and a narrative which helped its mass audience to make sense of such developments. In March 1854, during the New York State Assembly debate on the "Bone Bill" (which allowed medical schools to requisition for the purposes of anatomical instruction the bodies of people who died in poorhouses and prisons), Joseph Cook, an assemblyman from Genessee, rose to denounce the measure as "a bill to permit the immolation of this sacred image [the human body] upon the altar of science." According to Cook, physicians were "a class of men who . . . have neither hope of heaven nor the fear of hell before their eyes—who laugh at the jest and top off the bowl, while before them quivers the flesh of inanimate humanity." The language and content is recognizably Lippardian: "Let us not, . . . in our zeal to minister to a cold philosophy that would brutalize the finest feelings and defile the image of God. . . ." Invoking dark unnamed conspiracies, Cook condemned the bill as "a nefarious plot against the repose of the dead" and asked his fellow assemblymen to imagine "your wife or daughter . . . may wander from their homes in the moment of delirium. Would you wish her body—in the event of death—conveyed from the hospital to the dissecting block?"[33]

---

[31]They also received representation, in the realm of the natural, in the new technology of telegraphy and the almost ubiquitous performances of magnetizers and electrotherapeutic physicians; electricity was invisible but tangible.

[32]*Life of the Notorious Kidnapper, George F. Alberti. . . .* (Philadelphia, 1851) [New-York Historical Society]; Linden F. Edwards, "Cinci's 'Old Cunny': A Notorious Purveyor of Human Flesh," *Ohio Medical Journal* 50 (1954): pp. 466–69.

[33]*Albany Evening Journal*, 3-17-1854: p. 2.

Charges of Unethical Conduct Made by the Camden County Medical Society Against Samuel D. Gross, M.D. and Joseph Pancoast, M.D.

As introduced and transcribed by Henry H. Sherk and Katherine S. Simons

In the mid nineteenth century the medical profession was greatly concerned with the issue of "irregular practitioners" and who should or could practice medicine. A number of schools of medical theory had surfaced in those years and their varying degrees of success caused great concern among men and women who purported that they as "regular physicians" were the only legitimate group of individuals worthy of state-issued licenses for the practice of medicine. Naturopaths, Thomsonians, Eclectics, and others were a significant threat to "regular physicians," but homeopaths were their chief competitors. During the early nineteenth century, Samuel Hahneman had developed his theory of homeopathy and was recommending the administration of extensively diluted drugs with the intention of creating a mild, symptomatic response in the patient's body. Hahneman and his followers believed that this induced symptom would awaken the body's defenses and enable it to overcome specific diseases. Homeopathy developed a major following in the lay public and posed a serious threat to physicians who were attempting to bring together and utilize scientific medical practice as it was developing in those times. The chief virtue of homeopathic practice seemed to be that homeopaths at least did no harm and patients were not prevented from recovering on their own from the natural course of an illness. Allopathic practice, on the other hand, tended to be aggressively interventional and certainly many patients were harmed or actually died as a result of the various therapies offered by the so-

called scientific medical community. This was, of course, gradually changing as the discoveries of the great medical pioneers of the second half of the nineteenth century became more widely known. In 1869, however, the medical community was still struggling with these issues and associations with an irregular practitioner, particularly a homeopathic physician, were regarded as unethical conduct.

It appears that Samuel D. Gross and Joseph Pancoast attended patients in Haddonfield, New Jersey, in the spring of 1869, having been invited to do so in consultation with a Dr. Shivers, who was a homeopathic physician. Word of this reached members of the Camden County Medical Society who thought of themselves as being the regular ethical practitioners in the area and the Society lodged a formal protest with the Medical Society of New Jersey asking that the MSNJ forward their complaint to the Pennsylvania Medical Society. Dr. Gross and Dr. Pancoast apparently knew nothing of this and first learned about the concerns of the Camden County Medical Society when charges against them were read in the open meeting of the Pennsylvania Medical Society, in 1869. Dr. Gross and Dr. Pancoast were exonerated by the Pennsylvania Medical Society but Dr. Gross was outraged and wrote a number of letters to the physicians of the Camden County Medical Society chastising them for their formal protest against him. The correspondence between Dr. Gross, Dr. Pancoast, and the Camden County Medical Society is reprinted below.

A Report of Drs. Jennings and Comfort to the Camden County Medical Society

The undersigned having been appointed by The Camden County Medical Society at its late meeting as a Committee to investigate the truth of an allegation made before the Society both effect that Drs. Joseph Pancoast and Samuel D. Gross, two of the Professors at the Jefferson Medical College, having within the past year met in consultation in the village of Haddonfield, New Jersey, with B.W. Shivers a notoriously irregular physician of that place of the Homeopathic School of Practice: do hereby certify that they have attended to the duties of this appointment and find that the allegations of said sorrowful violation of our code of medical ethics on the part of said distinguished professors is only too true and susceptible of the most positive proofs.

Signed J.J. Comfort, M.D. and N.V. Jennings, M.D., Haddonfield, NJ May 20, 1869.

Haddonfield, New Jersey, May 20, 1869
Resolved that the delegates of this Society to the State Medical Society be directed to bring to the notice of that Society the fact that members of the Pennsylvania Medical Society have come into our state and met in consultation irregular practitioners and request the State Medical Society to instruct the delegates of the Pennsylvania Medical Society to call the attention of that body to the fact and ask their interference and also to instruct the delegates to the National Medical Convention to call the attention of that body to such things being done in other localities. Also resolved that the Secretary be requested to furnish our delegates with a copy of this resolution, also that Drs. Jennings and Comfort members of this Society be appointed a Committee to substantiate the truth of this report alleged against such of the Professors of the Jefferson Medical College named in the allegation.

Philadelphia, PA, June 18, 1869
Dr. H.G. Taylor—
Secretary of the Camden County Medical Society
Sir—My surprise was only equaled by my chagrin on hearing last week while attending the Meeting of the Pennsylvania State Medical Society at Erie, the Secretary of that Society read, in open meeting, the communication which on or about the eleventh of May last year addressed to that body as Secretary of the Camden County Medical Society, accusing Professor Pancoast and myself of a violation of the Code of Ethics by consulting with "a notoriously irregular physician, of the Homeopathic School of Practice" at Haddonfield, New Jersey.

Accompanying your communication is a report, signed by Dr. Jennings and Dr. Comfort, stating that they had investigated the charges preferred against Professor Pancoast and myself and that they had found, to use their own pathetic language that "the allegation of said sorrowful violation of our Code of Ethics on the part of said distinguished professors was only too true and susceptible of the most positive proof."

The circumstances under which this "sorrowful violation of the Code of Ethics" occurred are simply these, and will be found upon careful inquiry by your Committee to be equally true and "susceptible of the most positive proof."

Some time last April Mr. Tatem, the well-known and highly respected sheriff of Camden County, called upon me with a request to

visit his brother, Judge Tatem, whom in the spring of 1865 I had cut for stone in the bladder.

I asked him at once, as is my invariable custom, whether he had any physician, and, if so, whether he was a member of the regular profession, upon being assured that he was, I agreed to meet him, and accordingly went to Haddonfield the same evening, where I examined the case with him, and in due time returned to Philadelphia, never knowing until your communication was read in the Pennsylvania State Medical Society that I had conferred, on the occasion, alluded to, with a "notoriously irregular physician of the Homeopathic School of Practice." Such in a few words are the facts of the case.

When I paid the visit which has caused your Society so much trouble and sorrow to Judge Tatem I knew, personally or by reputation, none of the physicians of Haddonfield. Its regular and irregular practitioners were alike strangers to me. It was the second visit I had ever made to Haddonfield, the first having been a consultation held a number of years ago with the late Dr. Hendry; and it is, therefore, not surprising, that on the occasion in question, I should have been unwittingly betrayed into the hands of a homeopath, "a notoriously irregular physician" known as such to Drs. Jennings and Comfort and to the Camden County Medical Society, but of whose history and practice I was totally ignorant until enlightened by your letter and by the resolutions of your Society, read to my mortification and astonishment at the Meeting of the Pennsylvania State Medical Society last week, thus affording me the first initiation of this "sorrowful violation of the Code of Ethics."

I beg leave here to state for the benefit and edification of your Society that I was entrapped, in a similar manner, several years ago, by a Homeopath at Beverly, and that but for the courtesy, so strikingly in contrast with that of the Haddonfield physicians, of Dr. Townsend, of that village, I might possibly, have for ever remained ignorant of the sin which I had thus innocently committed. I might if I were not afraid of fatiguing you and your Society refer to other cases, in which not with standing the exercise of the utmost vigilance, I met with a like fate; but as they did not occur on Jersey soil, within the jurisdiction of the Camden County Medical Society, I assume it to be unnecessary.

I have no disposition after what I have here stated, to defend myself against the charge of unprofessional conduct made by your Society, my only regret is that so discourteous and uncalled for a charge should have emanated from such a body of men, many of

whom know me personally, and all by reputation. It was a thrust in the dark, designed either to wound my feelings, or to do me a personal wrong by placing me in a false position before the profession and the public. The character of your Society should have been a sufficient protection of my own. Its members, as pure and upright men, should have known that I have lived too long in the world, and enjoy too many posts of honor in my profession, to violate, knowingly and deliberately the Code of Ethics. They should have known that I have too much self-respect and too much respect for a profession which has so much and so frequently honored me with its confidence and support, to meet a Homeopath or any other medical excrescence in consultation for the sake of a paltry fee. They should have known that a man in extensive practice, like myself, cannot always, despite the most thorough precaution, avoid coming in contact with irregular practitioners, residing in regions of our country with which he is personally unacquainted, especially so long as there is no general or even local register of the numbers of the regular profession. I repeat, my reputation, which I hold sacred and beyond everything else on earth, my position as an old and well tried medical teacher, and the services which, in various ways, I have rendered to my profession during the last third of a century, in which no one ever dared to breathe a word of calumny against me, either in a moral or professional point of view, should have protected me from such a charge; a charge falsely based upon an assumption that I am in the habit of consulting with irregular practitioners, when knowingly, I never conferred with one in all my life. It does seem to me that it would have been much more in consonance with the character of high toned gentlemen, if the Camden County Medical Society, considering itself aggrieved by the occurrence in question, instead of carrying it up to the New Jersey and Pennsylvania State Medical Societies as a formal allegation, had taken the pains to inquire how it had taken place, and thus afforded my distinguished colleague and myself an opportunity for an explanation. Such a course would, at all events, have been courteous and neighborly, and in no respect inconsistent with the kindly feeling which should ever characterize the conduct and intercourse of professional brethren. Of the manner in which this matter was received by the Pennsylvania State Medical Society you will be able to judge by the perusal of the accompanying communication just received from the body in regard to the objects dated in my first communication from the permanent Secretary, Dr. William B. Atkinson.

Now that your Society has made the charge a subject of public notoriety, I hope that it will do me the justice to spread this communication with the resolution of the Pennsylvania State Medical Society upon its minutes, and send a copy of it with a similar request to the New Jersey State Medical Society.

I hope also that the New Jersey State Medical Society through its county societies will exert itself in procuring at an early day the publication of a register of the names of the members of the regular profession throughout the state, as recommended by me in my inaugural address before the American Medical Association at its meeting in May, 1868, as the only means by which such occurrences as these in question will be likely to be hereafter avoided.

Hoping that your Society will favor me with an early reply to this communication, I am, Sir, very respectfully your obedient servant Signed—S.D. Gross

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA, PHILADELPHIA, JUNE 17, 1869.

At the Annual Session held at Erie, June, 1869, after the Permanent Secretary had read the charges referred by the New Jersey State Medical Society against Professor S.D. Gross, Dr. Gross made a statement that he had met the person named in the charges but was unaware that he was in any way irregular: it was on notion Resolved, that the explanation of Dr. Gross be deemed satisfactory: the subject was therefore dismissed.

Attest.
Signed William B. Atkinson, Perm Sec'y

CAMDEN, JULY, 1869

Prof. S.D. Gross.

My Dear Dr.

Your communication of June 18, 1869, was received and its contents duly noted.

No one can more sincerely regret that a correspondence between so distinguished a member of the profession and myself should be opened in such inauspicious circumstances as the present, and I beg your attention whilst I state some facts relative to our medical organization of the state of New Jersey which will throw more light

on the subject matter of your letter, and make it plain that your communication should have been addressed to the Pres't or Sec'ty of the State Medical Society instead of to the Secy of the Camden Co. Med Soc. The New Jersey State Medical Society is a chartered institution, the oldest medical organization on the Continent, and our County Society only receives a delegate power and exists only at the will and pleasure of the State Society. Whilst that delegated power gives us a right to control the actions of each and every member of said county society—and regulates ethical questions amongst our own members, we have no right to step beyond the sphere allotted to us.

At our last meeting the charges alluded to in your letter were made against Dr. Pancoast and yourself and the Society took the precaution to refer the charges to a special committee for investigation with the direction to report to the Chairman of the Standing Committee of our Society (who is our reporter to the State Society) the result of their investigation. This duty was performed by the said committee and the Chairman of our Standing Committee enclosed a report with its own regular report to the Standing Committee of the State Medical Society, where it was read in due course of business.

From the above explanation you will see my dear doctor that the Camden Co Medical Society have at present no right to take any action in the matter and any communication relative to the subject should be made to the parent society through its officers. I must disclaim however the part of our county's society your statement that "it was a thrust in the dark, designed either to ruin my feelings or to do me a personal wrong" as the charge is made at the regular meeting of said society and the subject matter of said charge took the usual business course.

The reasons why the member making the charge did not "take the pains in inquire how it had taken place," is only known to himself, as the matter has not been discussed at any other time than at the regular society meeting. No one can be more pleased personally, than myself that the ethical view taken of "the matter" by the Penna' State Medical Society should be so unanimously complimentary to you but as I have said before "the matter" is entirely in the hands of the State Medical Society of New Jersey. I shall with great pleasure present your communication, with the appended certificate of Dr. William B. Atkinson, Perm Sec'y Medical Society of the State of Penna', to the Camden County Medical Society at its next annual meeting.

I would state that Dr. William Pierson of Orange, New Jersey is President, Dr. William Pierson, Jr. of Orange, New Jersey Sec'y—and Dr. Stephen Wickes of Orange, Permanent Chairman of Standing Committee to whom any communication may be addressed on the subject and with respect I am very truly yours

Signed—H. Genet Taylor
Sec'y Camden Co Med Soc'y

PHILADELPHIA JULY 27, 1869
Dr. McCray
President of the Camden County Medical Society
Sir—I received on Saturday last through H. Genet Taylor, his communication dated Camden July 7, signed by himself but proporting to have been written by you as President of the Camden County Medical Society in answer to a letter which I addressed to Dr. Taylor, a Secretary of that Society, on the 18th of June, explaining the manner in which I have been entrapped into a consultation with a homeopathic practitioner at Haddonfield, New Jersey, last April. I had hoped that my statement would at least have met with some degree of consideration and respect from your Society, especially as it was accompanied by a copy of the official resolution of the Pennsylvania State Medical Society, unanimously passed by that body immediately after they had heard my explanation of the matter in which the consultation in question had occurred, and exonerating me fully from any willful violation of the Code of Ethics; a code by which all honorable men in the profession are governed in their intercourse with each other. I have no right as a physician of Pennsylvania to dictate to the Camden County Medical Society the course which, as high toned gentlemen, they ought, in my judgement to have pursued under the circumstances; but I have an unquestionable right as a member of the medical profession and as an American citizen, to demand of them that justice be done me in the fullest sense of the term by placing me in a proper position before the profession and the public. It was natural to suppose that the communication which I sent to your secretary would at least have been submitted to your society at a special meeting, as you have, I understand, only one regular annual meeting, and that they would, as a result of their deliberations, have made a record of my statement, and used all proper means to relieve me of the necessity of going before the New

Jersey State Medical Society. Although you do not state the fact, I have it from an unquestionable source that no such meeting has taken place; and yet you assume to speak for your Society when you tell me that they have no longer any control over the matter; that their fiat has gone forth, and that the subject is now in the hands exclusively of the New Jersey State Medical Society beyond the reach or jurisdiction of your own: the plain english (sic) of this is that you do a man a wrong, and then when he takes the pains to explain himself, you cruelly informed him, not authoritatively but upon your own individual responsibility, that his case has been referred to a higher tribunal, you place yourself in a position of a judge, from whose decision whether right or wrong, there is no appeal. You have refused to convene the Camden County Medical Society because some of its members might be in favor of a reversal of your judgement. You have privately called together you myrmidons in order to prevent me from having an open hearing.

I am not at all disappointed in my expectations. It was hardly to be supposed that the men who took the initiative in this matter, would, or could, act in any other manner than they did and be true to their instincts. It was hardly to be supposed that having inflicted a deep wrong by their hasty, discourteous and ungenerous conduct, they would have the magnaminity to place my own in the light in which you will be sure to be viewed by all honorable, dispassionate, and right thinking men, both in and out of the profession. It is easy to perceive that the great object of the Camden County Medical Society in this affair was, not so much the preservation of the purity of the Code of Ethics as a willful attempt to persecute an innocent by placing him in a false position. It was not necessary for you to tell me that the New Jersey State Medical Society is a chartered institution, or the oldest medical organization on the continent. That was no news to me; but it was news to me that the most ancient medical society in America should stultify itself because the Camden County Medical Society did.

You say I am a distinguished member of the profession. Possibly I may be; but allow me to say that anything like flattery in a matter in which the only requirement is a simple act of justice, so illiberaly denied me by your Society, is not only out of place, but a positive mockery if not an insult. I am etc,

Signed—S.D. Gross

CAMDEN, NEW JERSEY AUGUST 2, 1869
Dr. S.D. Gross .
Sir—Your note of July 27, enclosed to Dr. H.G. Taylor, Sec. Camden Co Med Soc but addressed to me was this day received—concerning a matter which I am sorry to see has given rise to so much irritation and ill-humor on your part, which seems to have been much increased by the letter of the Secretary, Dr. H.G. Taylor, explanatory of the course of the Camden County Medical Society, in the matter of your meeting with a Homeopathic Physician in Haddonfield, which the letter endeavored as plainly as possible to point out to you the proper authorities to direct any communications concerning the matter at issue—i.e.—the Officers of the State Med Soc of NJ—

This permit me to say was done in all courtesy and with due consideration. Since the Camden Co Med Soc has been formed it has never yet found any subject or incident of sufficient importance to call for a convention of its members except at the regular time and place appointed by its constitution and in scanning its constitution and by-laws I have been unable to find any power delegated to me to call a meeting, unless at the request of the members. The members of the Society not having requested me to call a meeting in this case at issue—you can my dear sir see that I had no motive or desire, or right to call such a meeting even had I the power, more particularly as I was fully aware that the matter had passed entirely from our jurisdiction. I agree with you entirely that you "have no right to dictate to the Camden County Medical Society" and "as high toned gentlemen" we are presumed to have our individual views of medical ethics. I must beg to differ with you when you say that "I assume to speak for my Society" when you tell me that "they have no control over the matter." I have assumed nothing—the Secretary of the Camden Co Med Soc, merely informed you by letter of the constitutional law of our Society, as it is understood by us all in regard to the matter at issue and that too in the most courteous terms—if I read the letter aright—. I must also disclaim having placed myself "in the position of a judge from whose decision right or wrong there is no appeal" and I brand as false the accusation that "I have privately called together my myrmidons in order to prevent you from an open hearing." This I feel is my duty to say as the personal and professional friend of every member of Camden Co Med Soc. The gentlemen of whose friendship I am proud and men to whom you would not dare personally to apply such an epithet. The

remainder of your letter you must excuse my noticing as I find that it contains nothing but gross personalities and declining any further correspondence with you on this or any other subject I would respectfully refer you to the Sec'y of the Camden County Medical Society Dr. H.G. Taylor, who is the proper person through whom to address the Society in the future. I remain with due consideration yours, etc.

Signed A.M. McCray, SW Corner 4th and Pine St

PHILADELPHIA AUGUST 5, 1869

Dr. H.G. Taylor—Secretary of the Camden County Medical Society

Dear Sir—In a letter which I received last Tuesday from Dr. Alexander M. McCray, President of Camden County Medical Society, upon dated the second instant, I address myself to the Society in question, on the ground as he alleges, that he desires to have no further correspondence with me on any subject pertaining to that distinguished body or to use his own expression, on "any other subject." I am thus, it will be perceived, deprived of the privilege of addressing myself to a great functionary. Of this, however, I ought not to complain in as much as it is customary in all countries those who occupy high places to speak through their secretaries. Moreover I was not aware when I addressed my letter to the Camden County Medical Society that he was a man of such a nervous temperament, otherwise I should certainly have been more cautious about shocking his sensibilities. Such presumption unquestionably deserves rebuke. I must, however, not withstanding the position which the President of the Camden County Medical Society thinks proper to assume towards me, address a few words to him. This I shall of course, now that I am informed of his peculiar temperament do in as gentle and soothing manner as possible.

There is a certain bird which, when closely pursued, thrusts its head under its wing and thinks itself free from danger. The President of the Camden County Medical Society seems to me to be very much in that predicament, and I sincerely, hope that your wing may afford him a sufficient shield in that present emergency.

The very learned President of the Camden County Medical Society claims that he has had "no motive, desire, or right" to call a special meeting of that illustrious body in regard to the objects stated in my first communication, asking simply that justice should

be done me by placing me in a proper position with his own fellow members. I do not know—for he does not consent to inform me—whether he reached the sage conclusion by his own study of the Constitution and By-laws of the Society or whether he submitted that document to Mr. Browning and other distinguished members of the New Jersey Bar. He merely writes that "in scanning the Constitution and By-laws he had been unable to find any power delegated to him to call a meeting, unless at the request of the members." If the learned President were not living in this benighted age, one might suppose that he was descendent in the direct line from Solon; and one must be permitted to express his profound regret that so very able a man should have so greatly mistaken his vocation. Bench and bar of New Jersey certainly have much cause to lament such a loss. The President of the Camden County Medical Society seems to be as much afraid to violate any of the provisions of the Constitution as James Buchanan was to infringe the Constitution of his country when that country was threatened by a Civil War. It is well that a Society, especially one so illustrious as the Camden County Medical Society should stand upon its dignity and be guarded by such a custodian.

When I accuse your distinguished President, as I do in my second letter, addressed to him as the Chief Officer of assuming to speak for the Society he tells me, "I have assumed nothing" and in the same line adds, "the Secretary of the Camden County Medical Society merely informed you, by letter, of the Constitutional Law of the Society, as it is understood by us all in regard to the matter at issue and that too in the most courteous manner, if I read the letter a right."

This paragraph of the learned President requires a little analysis. In the first place, the letter here referred to was written by the President himself and transmitted by you, by his special order, to me. "I have assumed nothing." It is clear by his own showing that he assumed everything, not, however, without previous consultation with most, if not all, the members of the Society: for, in his letter to me under date of the second instant, he says: "As it is understood by us all in regard to the matter at issue." The underscored words plainly prove that such a consultation had taken place. It is pretty generally known that the learned President is a druggist as well as a practitioner of the healing art, and that he has a chamber in his store or shop wherein, when the Camden County Medical Society finds itself aggrieved, its members do congregate, and discuss the Constitution and By-laws. I am not informed of the precise name of

this chamber, but I would respectively suggest that it be here after known as "the pill or bottle room," as an appropriate appellation.

The President finds fault with me for having used the word "myrmidon" in the communication which I had the honor to address to him, and which has so much disturbed his equanimity that he will not hold any further communication with me. I am sorry that my pen should have dropped so naughty an expression, in as much as the President avers that his friends of the Society—those—who are in the habit of congregating in that little room—are not "myrmidons" but "gentlemen of whose friendship I am proud and men to whom you would not dare personally to apply such an epithet." Well! I cheerfully accept the amending, begging, however, leave to add that I hold myself personally responsible for any language that I have employed or may hereafter employ in regard to the Camden County Medical Society.

The distinguished President referred me for redress to the State Medical Society of New Jersey. He and his colleagues cover me with filth and then resort to the unmanly and cowardly expedient of shirking responsibility.

I have thus wasted, my Dear Sir, a good deal of time and some paper and ink upon the Camden County Medical Society. I have for the first time in my life been obliged to place myself in the attitude of defense against men who seem to be sunk so low in self-respect as to deny me a simple act of justice—that justifies which one gentlemen has a right to ask of another. If it was contrary to the Constitution and By-laws of the Camden County Medical Society to call a special meeting, it would have been perfectly competent to hold an informal one in the "pill or bottle room" in the President's drug store, if you please—to receive an explanation of the occurrence which has led to this correspondence as it was received by the Pennsylvania State Medical Society—and thus cause me to feel that I had to deal at least with gentlemen and high toned professional brethren.

I hope God and my profession who have higher claims upon me than the Camden County Medical Society will pardon me for having wasted so much time upon it. If the accompanying article which appeared in Forney's Press of the Third Instant had fallen into my hands sooner I should have been better able to regulate my conduct and thus save myself much trouble and annoyance. A medical society that is situated in such a community cannot be supposed to be possessed of the nicer sense of honor, or to have a very just appreciation of the professional dignity.

I am, Dear Sir, very truly, your friend S.D. Gross

A COPY OF COMMUNICATIONS WHICH APPEARED IN FORNEY'S PRESS OF THIRD INSTANT

New Spain

To the Editor of the Press;

Sir;

A Gross wrong and positive imposition is practiced on the taxpayers of the city by the niggerardly and marginally foreigners on the other side of the Delaware River; it consists in sending their children to our public schools to be educated. It is proverbial that the great mass of the people of that benighted region are not noted for extreme liberality; on the contrary, they have the unenviable reputation of being the meanest and most sordid people on the face of the globe. An old traveler, who has footed through many states, told me that it was the only place in which he was refused a morsel to satisfy the cravings of hunger, but to the subject, in justice to our people, I think councils should prohibit the continuance of the wrong in the future, in consideration of the solid and well known fact that the traveling public are taxed for the support of the schools of a race that they have no material interest in. If the people of that distant realm were not contracted in their views and intolerant in their notions, there would be some reason why they should be pauperized at the expense of a people goaded by onerous taxes; but let a poor person go to any part of Jersey and attempt to peddle the most trivial wares, if he or she are not provided with a license, they are ruthlessly arrested and casted to prison even though all their stock and trade does not amount to $5.00 in the world and for the terrible charge and crime of trying to eke out a honest living by supplying the penny wants of a community. Whilst reading this article "Rufus" suggested an "enigma." What is the difference between Delaware and New Jersey? Delaware sells what she cannot eat and Jersey eats what she cannot sell.

Signed—a Traveler in the State of Camden and Amboy Railroad Company, Philadelphia, July 31, 1869.

RESOLUTION OF THE CAMDEN COUNTY MEDICAL SOCIETY

Resolved that the communications from Prof'r S.D. Gross of Philad' to the Camden County Med Soc, through its President and Secretary are too insolent and infamous, to be received by this body and that it would be recommend that they (the communications) be copied and attested and retained in the possession of the Society, for future references necessary and that the original communication be

placed in the hands of the Chairman of the Camden County delegation to the NJ State Med Soc for its inspection, and dispositions, and that this Society would recommend and instruct its delegates to urge upon the State Medical Society the return of said communication to their author, as unworthy of the dispassionate consideration of any scientific or deliberate body, as any Medical Society ought to be.

Attest—H.G. Taylor
Secretary
Camden Co Med Soc'y—

Philadelphia, July 19, 1869.
To Drs. H.G. Taylor, Schenck, Brown, McCray—
Gentlemen:

Sometime last fall I was asked by an apparent gentleman, a stranger to me, to visit his wife in Haddonfield who was suffering from hip disease. I asked who was the attending physician and as I found his name one that I did not know I inquired further if he was a regular physician and was answered in the affirmative. A previous absence of 13 months in Europe had left me ignorant of medical men in that town. Until I heard of your communication to our state medical society I was utterly unconscious that I had met an irregular practitioner. I have never knowingly met one in consultation but how such a risk is to be altogether avoided I know not unless there be a register of regular physicians kept to which reference might be made.

I stand by my order and I love it, try to give the most generous construction to the acts of my medical brethren and think myself entitled to the same in return. I cannot therefore but think that the state of the course which has been taken would have been more courteous, just, and ethical for the Camden County Medical Society or any member of it to have addressed me a note informing me of the status of Dr. Shivers and allowing me an opportunity to put myself right on its records. Very respectively yours, Joseph Pancoast.

CAMDEN AUGUST 3, 1869—
Prof J. Pancoast—Dear Sir—

Your communication of July 19 directed to me as Secretary of Camden Co Med Soc has been recd. and should have been answered before this. It is the general impression among the members of Cam-

den Co Med Soc that the matter is now entirely in the hands of the NJ State Med Soc—but I shall take great pleasure in laying your communication before the District Soc—at its next meeting when I have no doubt it will receive due consideration—

Very respectfully yours—H. Genet Taylor

* * *

It is interesting to compare the responses of Dr. Pancoast and Dr. Gross to the charges read against them. Dr. Pancoast answered quietly with a brief note to the Society, whereas Dr. Gross clearly took great umbrage and let himself be manipulated by Dr. McCray and Dr. Taylor of the Camden County Medical Society. Dr. Taylor had served with great distinction in the Civil War as a regimental surgeon and had volunteered for duty behind enemy lines after the second Battle of Bull Run. Dr. Taylor had been present at 25 engagements during the Civil War and was highly regarded as a physician and surgeon in Camden County. Dr. Gross, of course, had not served and one wonders if this disparity in the backgrounds of the two individuals may have been a factor in the intensity of the correspondence. Dr. Gross made no mention of this episode in his autobiography and evidently thought it either too inconsequential or too embarrassing to justify recording of the event.

Dr. E.L.B. Godfrey in his History of Medicine and Medical Men in Camden County published in 1896 felt that the Camden County Medical Society was in the wrong in this matter and that the members should have given Dr. Gross an opportunity to "explain away" the events leading up to the lodging of formal charges. It appears, however, that the condescending if not arrogant tone of Dr. Gross's letters made any kind of reconciliation impossible.

Memoir of Mark W. Allam (1909–1998)

Alan M. Kelly

If there was ever a star in veterinary medicine in the twentieth century it was Mark Allam; he was a truly remarkable man who pioneered a revolution in veterinary education and clinical practice throughout the world. He was Dean of the University of Pennsylvania's School of Veterinary Medicine from 1952 to 1973 and he was without doubt the most successful dean of any veterinary school in the twentieth century. The twenty-one years under his leadership were the most important period in the School's 112-year history. He propelled the School upward to the pinnacle of veterinary medicine and established it as an internationally renowned institution.

Mark Allam touched peoples' lives in many many ways. This was the key to his astonishing talent for raising funds from the private sector. He prevailed because he thoroughly enjoyed life and put all of his remarkable energy and talent into what he was doing. He loved people, he loved animals, and he was intensely concerned with the well being of both; these were the ingredients that made him such a great human being and veterinarian. Optimism was one of his hallmarks. He was unfailingly cheerful and he never saw any barriers he did not think he could overcome. If there was ever the slightest doubt in his mind, his favorite Martini soon dispelled it. More than anything else, however, Mark was totally dedicated to the School of Veterinary Medicine and he believed implicitly that what he was doing was right. He embodied the saying that "if you want something badly enough and believe in it deeply enough—it will happen." And it did happen. New Bolton Center, the School's large animal facility, was created in Chester Country, including construction of Widener Hospital, Alaryk Myrin Research Building, Phillip and Georgia Hoffman Center for Reproductive Studies, C. Mahlin Kline Orthopedic and Rehabilitation Center, and the Dormitory and Alumni Hall. Allam House, named in his honor, became

an elegant manor and the Gladys Rosenthal Teaching and Research Building went up in Philadelphia.

When Mark became the Dean of the Veterinary School in 1952, the School was in dire straits, having only just managed to survive the demise of horse transportation in the 1920s, the Depression in the 1930s, and then World War II in the 1940s. The total research budget of the School in 1952 was $35,000. When Mark stepped down in 1973, this had mushroomed to $2,860,000, an eighty-fold increase in research support. At that time the School had more research support from the National Institute of Health than sixty percent of medical schools in the United States and this remains true today. Veterinary clinical specialization was pioneered at Penn under Mark's leadership and was starting to spread throughout the nation when he stepped down. This development created an immense advance in the clinical care of animals. Mark played an additional role in these advances as a superb surgeon and a founding father of the American College of Veterinary Surgeons. The annual Mark W. Allam Lecture recognizes his contribution to the College of Physicians of Philadelphia.

The breadth of Mark's accomplishments are astonishing. Not only was he Dean of the School for twenty-one years, he was Chair of Media School Board for sixteen years. He was skilled at carriage driving and a celebrity at the Devon Horse Show. Mark was the first veterinarian to be elected to the College of Physicians of Philadelphia, he was President of the Quaker City Farmers, of the Philadelphia Society for the Promotion of Agriculture, and he held numerous other prestigious positions in local and national organizations. As if this was not enough, he used his spare time to become an expert cabinet maker and crafted several fine pieces of furniture.

Mark Allam was a charming gentleman who led a life that was a model for all of us, filled by generosity, determination, wit and poise.

Memoir of Mark W. Allam (1909–1998)

*Katherine R. Sturgis**

Mark Whittier Allam was born in Fernwood, Pennsylvania. The happy circumstance of his middle name and the woodsy sound of his birthplace may have been partially responsible for this remarkable man's happy disposition and optimistic turn of mind. Anyone who works with and loves animals is a lovable person—choosing to understand, as he must, those who cannot communicate with words.

A graduate of our public schools, Allam received his V.M.D. from the University of Pennsylvania in 1932 and, for the next thirteen years, he practiced general veterinary medicine in Media, PA. Dr. Allam audited a course in the Surgical Laboratory at the University of Pennsylvania's Graduate School of Medicine from 1936 to 1938. From 1943 to 1945 he was a part-time instructor in veterinary surgery at his alma mater; then Assistant Professor from 1945 to 1948; Associate Professor of Surgery from 1948 to 1951; and, finally, Professor and Chairman of the Department of Veterinary Surgery from 1951 to 1953. He became Dean of the Veterinary School in 1953.

From 1946 to 1952, Dr. Allam was a member of the Harrison Department of Surgical Research at the University of Pennsylvania School of Medicine, where he worked on peripheral nerve regeneration under Drs. Frederick Lewey and Francis Grant. Among Dr. Allam's other important projects were his Directorship of the Interdisciplinary Cancer Research Project, membership on the Board of Managers of the Wistar Institute of Anatomy and Biology. He was Chairman of the Board of Regents of the American College of Veterinary Surgeons in 1966 and 1967. He was a member of the Executive Board of the American Veterinary Medical Association Foundation and of the Advisory Board of the Bureau of Medicine for the Food and Drug Administration. He wrote numerous articles on veterinary medicine and was the first non-M.D. ever to become

*Deceased

a Fellow of the College of Physicians of Philadelphia. Mark Allam was interested in people and in the community. He was President of the Board of Education of the Media Borough School District from 1941 to 1960.

In the summer of 1972, when Mrs. Frank Elliot planned a beautiful dinner for me at the College, Dr. Allam invited the Elliots, my husband, and me to the New Bolton Center to choose an equipage in which he would drive us from the Elliot's home in the historic Reynolds-Morris House on Eighth Street and Locust to the College. We chose a landau in which the Empress Eugenie was said to have made her escape from Paris. Apparently the American dentist, Evans, after whom the University of Pennsylvania Evans Institute of Dentistry is named, drove the fascinating Empress in this very equipage during part of her escape. Having made our choice, Mark put a heavy leather apron on me so that I could sit beside him in the sully with a fringe on top after which he drove the six of us over the New Bolton Center grounds to a country lane where we stopped and ate a fried chicken lunch. It was the hottest day I ever remember. Never before had I seen horses in "a lather." "What's wrong with Queenie and May?" I asked Mark. "They're in a lather," he replied—and jumped down to brush off the copius, sudsy sweat with a great turkish towel he had brought along for such a contingency. On October 20th, the day of the dinner, Dr. Allam, in a top hat, appeared at the Elliott's, reins in hand, coachman beside him, surgical resident-footman behind, and drove Maly and Jack Gibbon, Katherine and Sam Sturgis behind a police escort out Walnut Street and up Twenty-second street to the College.

Full of fun, full of wisdom—Mark Allam: We salute him; we love him!

Memoir of Emily Hartshorne Mudd (1898–1998)

Luigi Mastroianni

May 5, 1998 marked the completion of a remarkably full and productive life when Emily Hartshorne Mudd died peacefully at home in Haverford just shy of her one hundreth birthday. Emily Mudd's career was characterized by one innovative contribution to society and to human well being after another. She was truly a pioneer. In 1927, she established Philadelphia's first family planning clinic. At a time when dispensing contraceptive information was a criminal offense, she circumvented this "minor obstacle," as she put it, by conveniently being pregnant. This meant that under Pennsylvania law she could not be incarcerated. This early experience in contraceptive counseling led her to the belief that family planning involved more than simply dispensing contraceptive advice and that serious issues concerning interpersonal relationships needed to be addressed. She focused on the formation of a new entity and these efforts soon created the Marriage Council of Philadelphia. She served as the Council's first director but recognized that she would benefit from additional formal training. At the time, she possessed no formal degrees, having studied briefly at Vassar and taken some additional courses in landscaping and architecture in Boston. After her marriage to Dr. Stuart Mudd, Emily Hartshorne Mudd had worked as a volunteer in his laboratories at Harvard, the Marine Biological Laboratory, and at the Rockefeller Foundation. The Mudds published fourteen papers together, the first of which appeared in the July 1929 issue of the *Journal of Immunology*. Their research focussed on spermatozoa. The Mudds' observations on methods used to separate male and female producing sperm were published in the *Journal of Experimental Medicine*. This experience might very well have helped catalyze the interest in contraception that persisted throughout Emily Mudd's career.

In the early phases of Emily Mudd's Marriage Council work, she enrolled in the School of Social Work at the University of Pennsylvania. She was able to use her experience at the Marriage Council as field work for a Ph.D. Shortly after receiving her degree she ac-

cepted an academic appointment in the Department of Psychiatry at the University of Pennsylvania and in 1956 she advanced to the rank of Full Professor, having skipped the intermediate step of Associate Professor. She was the first woman to achieve the rank of Professor at the University of Pennsylvania's Medical School. This was in recognition of her academic productivity but also, as Johnathan Rhoads, Chairman of the Promotions Committee at the time, noted, in recognition of the remarkably innovative nature of her work. Kenneth Appel, as Chairman of the Department of Psychiatry, had established a Division of Family Study and Dr. Emily was appointed to be its first director. At the School of Medicine she launched a series of educational initiatives in the Departments of Psychiatry and Obstetrics and Gynecology. In 1966 she collaborated to establish a formal course entitled "Introduction to Reproduction," which covered aspects of reproductive biology, reproductive medicine, and sexuality. The course was an elective but nearly every student enrolled. In 1998 it was officially incorporated into the required program for the second year.

Emily Mudd's educational legacy continues to this day. Her efforts are most cogently represented at Penn through the Stuart and Emily Mudd Professorship. The professorship was established by Stuart Mudd, whose will stipulated that "This professorship is suggested in considerable part as a tribute to my wife, Emily B. Hartshorne Mudd, who has been ever mindful of the fundamental need for quality and quantity of population and who has dealt creatively with the many facets of human interactions within families." Emily Mudd's constant and direct involvement included programs to address teen pregnancies, which she, with Dr. Helen Dickens, described in detail in a 1975 publication. The "Teen Program," as it is called, has served as a prototype for many similar efforts throughout the United States.

Emily Mudd often recounted her early interaction with Dr. Alfred Kinsey, whose ground-breaking research on human sexual behavior helped to change our thinking on such matters. Mudd met Alfred Kinsey through Dr. Robert Latau Dickenson, a pioneer in reproductive medicine. In 1944 Dickenson was responsible for Kinsey's meeting and subsequently successful interactions with Lawrence Saunders, the Philadelphia publisher who courageously decided to publish Kinsey's work, *Sexual Behavior in the Human Male*. Emily Mudd later served as one of two external consultants for Kinsey's second book, *Sexual Behavior in the Human Female*, an assignment that caused her mother serious concern. In response to her mother's

written admonition, Emily Mudd wrote, "Have we any right to refuse to examine some facts which, although perhaps surprising, may ultimately be important for the growth and development of women as creative persons in their own right . . . With your courage, mother, you surely do not fear truth, even though all of us may for a time be confused by the social implications of new thoughts." She went on to assure her mother that her family name—Hartshorne—would not be mentioned and added in jest, "I hope this will bring you relief." Dr. Emily was a pioneer in the family planning movement, a staunch advocate of education in sex and human behavior. She had a no nonsense demeanor. Her reminiscences on the work of Alfred Kinsey were published in the College's *Transactions and Studies* in 1994. These were described by Thomas Horrocks as "Indeed a story of courage including that shown by the young girl from Philadelphia whose strength and conviction, sense of purpose, and deep compassion have contributed so much to the health and welfare of the local community."

In 1970, William Masters, the founder of the Reproductive Biology Research Foundation in St. Louis, asked Emily Mudd to collaborate with him. For the next two years Mudd commuted to St. Louis, where she developed prototypes for the treatment of sexual dysfunction. In 1971 and 1972, she took on the cause of reproductive rights when she was asked by Governor Schapp to serve as co-chair of the Pennsylvania Abortion Law Commission. Her work had a major influence on subsequent abortion legislation.

We have touched on but a few of Emily Mudd's accomplishments. Collectively, they have been recognized through numerous honors and awards. On one such occasion (The Lucretia Mott Award), she stated, "The last thing in the world I wanted was any more honors," but they continued to come in spite of her protestations. At the age of ninety-five, she received the American Philosophical Society's highest honor, its Benjamin Franklin Medal. At the January 1995 High Tea, the College of Physicians presented its Distinguished Service Medal to Emily B. Hartshorne Mudd. President Robert H. Bradley, Jr. described Dr. Mudd as an "internationally renowned author and leader in the development of marriage counseling and family planning" and "one of the earliest counselors to bring sexual issues into the realm of marriage counseling." A fellow of the College since 1973, Emily Mudd, through distinguished service to medicine and to science, had brought honor and distinction to the College and had made exceptional contributions to society. During the course of her long career, Emily Mudd was an

educator—one who taught principally through example. She was a proponent of preventive medicine at a time when active intervention was the standard of the day. She promoted genuine scholarship and the impact of her efforts to combine reproductive medicine with the behavioral and social aspects of human reproduction and sexuality continues to be extremely important. She was an internationalist who influenced the lives of countless colleagues from various parts of the world, ever mindful that all of us have a responsibility for others both here and abroad. She was a humanist who emphasized the importance of developing the careers of young people. Her personal life was characterized by the sense of purpose she exhibited in other areas. Her meaningful interaction with Dr. Stuart Mudd continued for more than half a century, and later her marriage to Fred Gloeckner, Honorary Associate Fellow of the College, served as examples of true commitment and concern. Well into her nineties, Emily Mudd continued to have a positive effect on the lives of those about her. On September 27, 1988 at the College of Physicians, Fred Gloeckner marked Emily's ninetieth birthday by arranging a celebration that was attended by two hundred of her friends. The issue of *Transactions and Studies* that includes Emily Mudd's account of her experiences with Alfred Kinsey also contains W. Thatcher Longstreth's 1993 memoir of Fred H. Gloeckner.

Emily Mudd is survived by four children, Emily Borie Mitchell, Stuart Harvey, Margaret Clark, and John Hodgen, whose own lives reflect the values that she represented. For the 1990 *Who's Who in America,* Emily responded to a request to comment on her life and philosophy by stating that "In my philosophy it is most important to learn ways of communicating with those around us. Seeking to understand and seeking to be understood became imperative. I have learned that what makes one person comfortable and happy may not necessarily do the same for another. My work has increased my tolerance of difference and my respect and belief in the intimate and ultimate strength of human beings." Emily Mudd's philosophy is perhaps best summarized by one of her favorite quotations from Browning: "Do what you cannot do so your soul will grow."

Notes on Contributors

Alfred P. Fishman, M.D. is the William Maul Measey Professor of Medicine Emeritus and Associate Dean for Program Development at the University of Pennsylvania. He served as President-elect of the College of Physicians of Philadelphia from 1994 to 1996 and then as President from 1996 to 1998. An international figure in the field of pulmonary medicine, Dr. Fishman was also Chairman of the Department of Rehabilitation Medicine from 1990 through 1998.

Lynda Stephenson Payne, R.N., Ph.D. is a Visiting Assistant Professor and Scholar in History at Oberlin College. She received her Ph.D. in history from the University of California at Davis. Currently she is completing a book manuscript concerning the emergence of clinical detachment in early modern British medicine. Dr. Payne has also had careers as a critical care nurse, respiratory therapist, and medical social worker.

Michael Sappol, Ph.D. was the 1997–98 Scholar-in-Residence at the Francis C. Wood Institute for the History of Medicine at the College of Physicians of Philadelphia. He is currently a medical historian at the National Library of Medicine. His full-length study of the cultural politics of anatomy in nineteenth-century America, *A Traffic of Dead Bodies*, will be published by Princeton University Press in 1999.

Henry H. Sherk, M.D. is Professor of Orthopedic Surgery at MCP/Hahneman University. He is a fellow of the College of Physicians and the historian of the Camden County Medical Society. He recently published *Colleagues and Competitors*, a history of the 150 years of the Camden County Medical Society.

Katherine S. Simons, M.A. graduated from Bryn Mawr College and did graduate work at Case Western Reserve University. She has presented and published historical work and biographical papers on the authors Charlotte Perkins Gilman and Philadelphia physician S. Weir Mitchell. Her current research focuses on a review of the unpublished letters and papers of Dr. Mitchell.

College of Physicians of Philadelphia 1998

Marc S. Micozzi, M.D., Ph.D., *Executive Director*

Thomas A. Horrocks, M.A., M.L.S., *Director of the Francis Clark Wood Institute for the History of Medicine and Director of the Historical Division of the Library**

Andrea L. Kenyon, A.M.L.S., *Director of the Katherine A. Shaw Division of Public Services and Programs*

Marjorie M. Smink, M.S., *Director of the Library*

Gretchen Worden, *Director of the Mütter Museum*

Antonia Oberthaler, *Director of Fellowship and Services*

Dick Levinson, *Director of Public Affairs*

Benjamin R. Pierce, *Chief Operating Officer*

Raymond O'Donnell, *Controller*

Deborah Julie Franklin, M.D., Ph.D., *Interim Editor, Transactions and Studies*

*Through October 1997

TRANSACTIONS & STUDIES OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XIX December 1997

Editorial v
DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1997 1
ALFRED P. FISHMAN

Annual Report of the Katherine A. Shaw Public Services Division 7

Financial Report of the College of Physicians of Philadelphia, July 1996–June 1997 13

Forum on Disability and the Presidency of the United States

Opening Remarks 15
SENATOR ARLEN SPECTER

When the President is the Patient 19
MARC S. MICOZZI

President Lincoln's Fatal Wound: An Experimental Study 25
JOHN K. LATTIMER

Resuscitating the Twenty-fifth Amendment: Mandating a Second Opinion for the Determination of Presidential Disability 39
BERT E. PARK

The Illness and Death of President Franklin D. Roosevelt 53
HUGH E. EVANS and ROBERT H. FERRELL

Visitor Survey after viewing "When the President is the Patient" 65
COLLEGE STAFF

Feature Articles

Innoculation, Patients, and Physicians: The Transformation of Medical Practice in Philadelphia, 1730–1810 67
SARAH BLANK DINE

A Nineteenth-Century Literary Physician: S. Weir Mitchell's Medical Work and Imaginative Writing 95
NANCY CERVETTI

From the Historical Collections of the Library

Mary Putnam Jacobi's Letter of Protest to S. Weir Mitchell As introduced and transcribed by 110
NANCY CERVETTI

Memoir

Daniel Leonard Shaw (1922–1997) 115
ROBERT H. BRADLEY, JR.

Notes on Contributors 117

TRANSACTIONS & STUDIES
OF THE
COLLEGE OF PHYSICIANS OF PHILADELPHIA

Series V Volume XX December 1998

Editorial v
DEBORAH JULIE FRANKLIN

Report of the President of the College of Physicians of Philadelphia, 1998 1
ALFRED P. FISHMAN

Report of the Katherine A. Shaw Public Services Division 6

Report of the Library 13

Selected Reports from Fellows of the Wood Institute for the History of Medicine 20

Conference Notes: Hippocrates and Modern Medicine

Keynote Speech 41
ALFRED P. FISHMAN

Feature Articles

"A deep fund of hatred and resentment": Clinical Encounters in Eighteenth-Century England 51
LYNDA STEPHENSON PAYNE

"The foul altar of a dissecting table": Anatomy, Sex, and Sensationalist Fiction in Mid-Nineteenth-Century America 65
MICHAEL SAPPOL

From the Historical Collections of the Library

Charges of unethical conduct made by the Camden County Medical Society against Samuel D. Gross, M.D. and Joseph Pancoast, M.D.
Introduced and transcribed by 98
HENRY H. SHERK AND KATHERINE S. SIMONS

Memoirs

Mark W. Allam (1909–1998) 115
ALAN M. KELLY

Mark W. Allam (1909–1998) 117
KATHERINE R. STURGIS

Emily Hartshorne Mudd (1898–1998) 119
LUIGI MASTROIANNI

Notes on Contributors 123